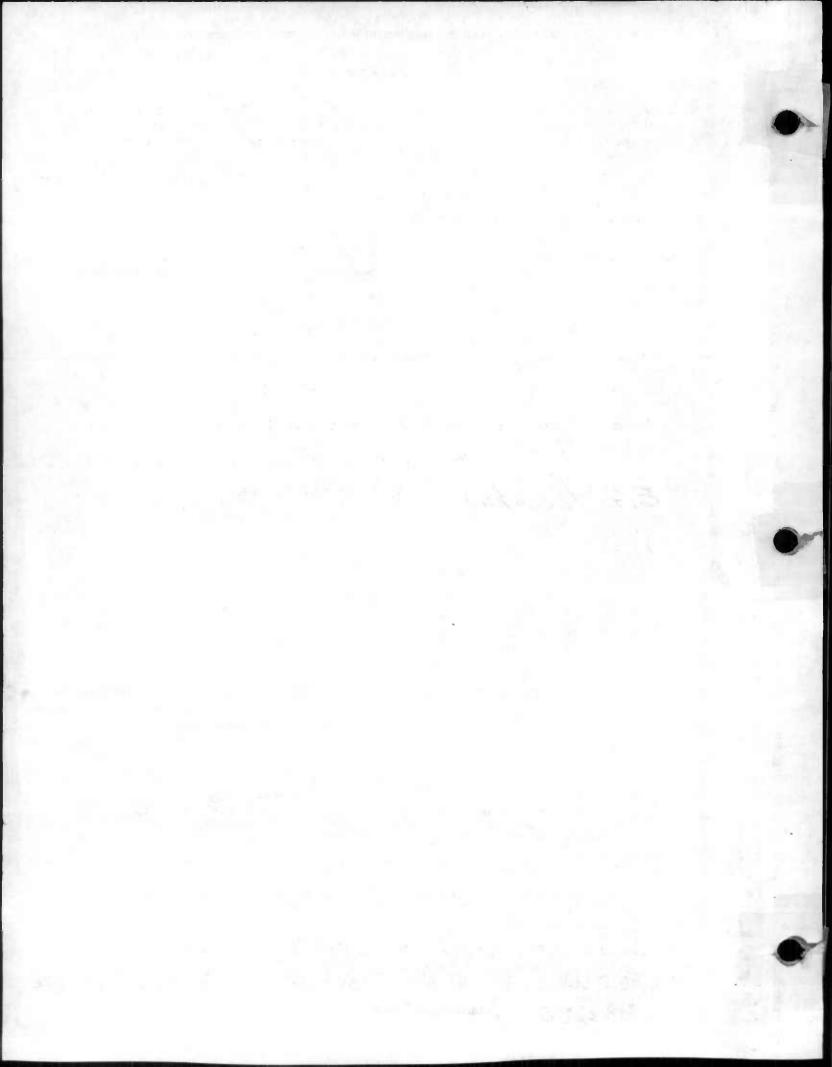
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Physician	n	1. Decedent's Name (First, Middle, Last)		Dete of De Month		ay Yea					
/Medical		Nina May Broadway 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	3 10 10 10 10	11,	1998	7:45AM				
Examiner	r			ation of Deat		Ic. County of De					
Funeral		11923 Jericho Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Bradshaw If Under 24 Hrs.	8. Date of Bir		altimor					
Director		218-38-4931 1 M 20(F 92 Yrs. Months Days	Hours Min.	8. Date of Bir (Month, De Feb. 1	19, Yea	906 Oxf	Birthpiace (State or Fo Country) Ford ,Marylar				
and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City L				
rolling	5	Maryland Baltimore Bradshaw					1 ☐ Yes 20				
or 28a-1 show	2	10e. Street and Number 10f. Zip Code			10a. 0	Citizen of What					
38 o	2	11923 Jericho Road 21021				S.A.					
r ttems 23s	2	11. Marital Status 12. Was Decedent Ever In U.S. 13. Was Decedent of F	Hispenic Origin? (Spec	ify Yes or No		14. Raca - Ar	mericen Indian,				
	2	ò	ò	2	ò	Armed Forces? If Yes, specify Cub 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No	an, Mexican, Puèrto R Specify:	ican, etc.)		Black, W	hite, etc. Vhite
ygiene. The than "natural", it, me we call Ext. Completed by	200	15. Decedent's Educetion 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done	petion		16b.	Kind of Busines					
ner and the	2	(Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) (Give kind of work done life. DO NOT use retire	d)								
Pr. In the Co.	3	12 yrs. n/a Homemaker			Hon						
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Meone. To Be Compl	5	17. Father's Name (First, Middle, Last)	18. Mother's Name (, Maide	on Sumame)					
d Men merke metic	2	Samuel Harrison	Nina Timm								
than 7 is r		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street									
Hear Hear other	-	Mrs.Alfleta M.Shockley(Daughter) 11923 Jericho 20a. Method of Disposition 20b. Place of Disposition (Name of	Road Brad	dshaw,		y Land 2 Location - City					
or in the land of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State									
ortan Injur	-	4 Donetion 5 Other (Specify) Franklinville Pres.Ch. 21. Signeture of Funeral Servica Ligarinee 22. Name and Addre		14/98	Bra	adshaw,N	Maryland 2				
Department of Important: If any Injury or once.			sahn Funera	al Hom	e						
	4	23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying shock, or heart failura. List only one cause on each line.	air Road k	(inasv	ille	e,Md.21	087 Approximate Interval Batween				
g physicial and as the burakunsti		Immediate Cause (Final disease or condition resulting in death) Bacterial Sepsial Dua to (or as a consequenca of): Bacterial Sepsial Dua to (or as a consequenca of): b. Premono Due to (or as a consequence of): fany, laading to immediate cause. Enter Underlying Cause (Disease or Injury hat initiated events resulting In death) Last Due to (or as a consequence of): d. dawlets mellitus	ident,	boar d	mh	nmay f	untion				
d by the attending to the attending to the attended for use.							i				
ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv	en in Part I.				ite to the cause of d				
be det		age, delilitation,		10	Yes	2□ No 3□	Probably 4 ☑ Un				
should should		age, delilitation, deculitus ulceration		24a. Wes perfo	an aut		. Were autopsy find aveilable prior to completion of caus of death?				
to has b				10	V00 1	2 PNo	1 Yes 2 No				
rector, pag		25. Was case rafarred to medical	26. Placa of Death (2 32 140	10165 20100				
		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Oth		-		6 DOther (Sr	nacify)				
r death. ector: After this by the funeral d	2	77. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury Wor	The state of the s	d. Describe h	-		outy)				
and in		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)	28	f. Location (5 City or Tox	Street a	and Number or i	Rural Route Number				
Funer Funer float		29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the time of the best of my knowledge, death occurred at the best of my knowledge.	ne, date and place, and pinlon, death occurred	d due to tha d	cause(: date ar	s) and manner and place, and de	as stated. ue to the ceuse(s)				
Med Med	80	9b. Signeture end title of certifier 29c. License	e number		29d D	ate signed (Moi	oth Day Year)				
S 5 0			5568		4	11210	0				
6	3	Name end address of person who completed cause of death, (Item 23a) (Type, Print)	1161.106	and and	1	113/7					
State	3	BKWTOOD LEWIS EDKIGH, MD UB 13VA 1. Date filed (Month, Day, Year) 32. Registrar's Signature	hury vie	ANS	1	AL10,	MD2120				
Registrar	н	APR 21 1998 Pulie Devidson Randell			,						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2502 Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth **Physician** 10:15am lle ARNE toci 0. BLASCHE SR. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, giva street and number) County of Death Examiner Himore Birthplaca (Stata or Foreign Country) If Undar 1 Y Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 6. Sax **Funeral** Months Days 1X M 2 □ F Hours 88 Director 275-01-2167 July 12, 1909 Norway Usual Rasidance of Decedent 10c City Town or Location 10d Inside City Limits 10a State 10h County ? is merked other than 'naturel', or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 Yas 2 1 No Baltimore Director Middle River 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21220 13. Was Decedant of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Maxican, Puerto Rican, atc.) Funeral 115 Glider Drive 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 14. Race - American Indien, Bleck, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 ☑ No Specify: ğ 3√ Widowad 4 Divorced White Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15 Dacedant's Education (Specify only highast grada completed) Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) MAchinest 12th Grade Glenn L. Martins 18. Mothar's Nama (First, Middle, Maidan Surnama) 17. Father's Nama (First, Middla, Last) Be Emil Blasche unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Health I James Michael Haney/ Friend 20a. Method of Disposition 115 Glider Drive Baltimore. MD 21220 20b. Place of Disposition (Nama of cemetary, crematory or othar place) Data 20c. Location - City or Town, Stata Department of h Important: If its Pages 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramovel from Stata 4/21/98 Metro Crematory Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Connelly Funeral Home Of Essex 300 Mace Ave. Baltimore, MD 21221 Do not antar tha moda of dying, such as cerdiac or respiratory arrast, olications that caused the death one cause on each line. **Physician** /Medical Immadiata Ceuse (Final disease or condition resulting in daath) Examiner Examiner physician and the bunal-transit Sequantially list conditions, if any, leading to Immadiate ceusa. Enter Undarlying Causa (Disaasa or Injury that initiated avents rasulting in deeth) Lest that the death certificate be execu ivision of Vital Records, P.O. Box 68760, Physician/Medical the Dua to (or as a consaguance of) 80 use signed by the a d be deteched f 23b. Did tobecco use contribute to the ceuee of death? Part II. Other algnificant conditione contributing to death but not rasulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 2 q 24b. Ware autopsy findings evailabla prior to complation of causa of death? Respiratory Failure 24a. Was an autopsy Completed pege 2 1 ☐ Yas 2 ☐ No 1 Yas nding Physician: 25. Was casa rafarrad to madicel axaminar? 26. Placa of Daath (Check only ona) Be Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 10 1 Inpatiant 2 ER/Outpatiant 3 DOA funeral 27. Mannar of Daath 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 28e. Data of Injury (Month, Day Year) Certification: 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant investigation 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred et the time, date and place, end due to tha causa(s) end menner es stated. Medical Examinar: On the basis of axamination and/or invastigetion, in my opinion, daath occurred at tha time, dete end place, and dua to the ceuse(s) and mannar stated. 29a. Certifier edicai

within 24 hor To the Fune completely ti

State Registrar

29b. Signatura and titla of certifian

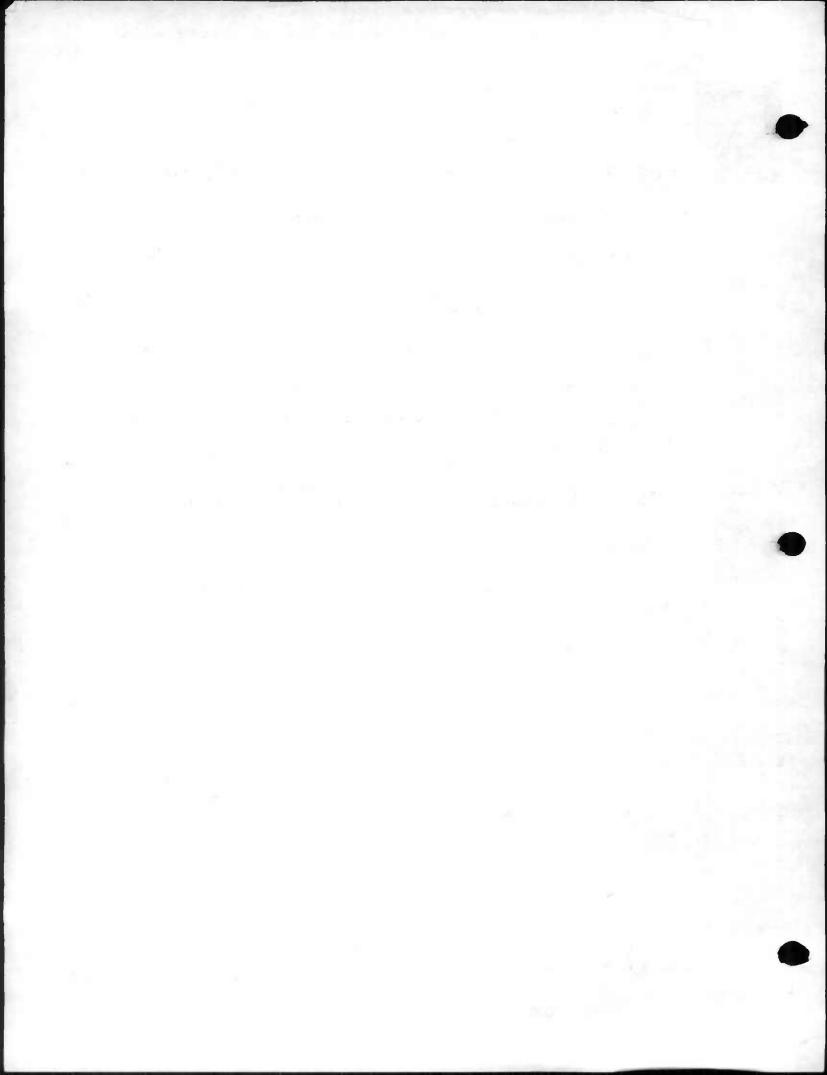
31. Data filad (Month, Day, Year)

29c. Licansa number

29d. Date signed (Month, Day, Year)

. 22 F- 1585

					Certific	ate of	Death		Reg. No.									
Dhuaisis		1. Decedent's Neme (First, Middle, Las	st)					2. Dete of De Month	eeth Day	Yaer	3. Time of Death							
Physicia /Medica	_	Raymond	Cole					Apr:1	1914	1998	05:44							
Examine	_	4e. Fecility Name til not institution, give		-				r Location of Deat	h 4c. Count	y of Deeth	CHy .							
		John' Hopk. W	Bayv	iew			Baltims	(6	Ba	14.200								
Funeral Director		5. Social Security Number 6. S 217-34-9539	ax 7. Age	(In yrs. last b	Yrs. If Un Mont	dar 1 Yaar hs Deys	If Under 24 Hi Hours Min		av. Year)	9. Birthple Count Mary	ace (Stata or Forei							
2 2		Usuel Residence of Decedent 10e. Stete 10b. County		40. Oh. T.														
show anyle	-			10c. City, Tov	vn or Location	D - 0 +				10	d. Inside City Lim							
N 95 1	ot o	Maryland Baltimo	re			Balti	more				1 ☐ Yes 2 X 1							
ath with the Maryler 23s or 28s-f show	Funeral Director	10e. Street end Number 3516 E. Joppa	Road	Road 10f. Zip Code 21234						tizen of What Country?								
0 =	þ	11. Marital Status 1 □ Naver Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 2 Yas 2 1 N If Yes, Give V A Year or Dates:	0 +		ecadent of F specify Cube s 2 XNo		Specify Yes or No arto Rican, etc.)	Specia	ce - America ck, White, e								
72 h netu lical	Completed	15. Decedent's Ed (Specity only highast gra-	lucation		Decedent's U	sual Occup	ation	ndkina	16b. Kind of B	Business/Ind	ustry							
Ban Ban	힐	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO	T use retired	during most of w	UIKIIG										
wd w or th	5	9th grade			Owner				Antiqu	e Busi	iness							
of file	Be	17. Fether's Neme (First, Middle, Last)						eme (First, Middle	,	/								
Ment Ment rke	၉	William August	tus Cole				Golda	Marie	Bobbli	tz								
end ema		19e. informent's Name/Relationship (7		19	b. Mailing Addr	ess (Street	and Number or I	Ru <i>ral Rou</i> te Numb	er, City or Town	, State, Zip	Code)							
and alth		Cora E. Cole lu	rife)	3	516 E.	Joppo	Road,	Baltimor	e, MD	21234								
of He		20e. Method of Disposition		20b. Pleca	of Disposition (Name of	ce)	Dete	20c. Location	- City or Tov	wn, Stata							
Page ent nt: If ny or	- 1	1 Burial 2 Cremetion 3 ☐ 4 Donation 5 Other (Specify			ood Cer			4/21/98	Baltim	ore N	laruland							
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; any injury or other traumatic event, it a Medical Exa		21. Signature of Funerel Service Licen:			22. Name Sch	and Addre	ss of Fecility 2. Funera	l Home.	Inc.		100 09 000 100							
	_	23a. Pert 1. Enter the disease, or companion, or heart failure. List only of	Willer	n	970	Belo	iir Rd	Baltimo	re. MD	21236	5							
eath certificete be executed attending physician and for use as the buriel-transit	ai Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury			TANK y consequence		lower	exteni	1.05									
death certificate be executed a strending physician and od for use as the bunel-transit	an/Medical	thet initiated events resulting in deeth) Last	d	Due to (or es e	consequence o	of):												
0 00 7	Sici	Pert II. Other eignificent conditions co	entributing to death but	t not rasulting	In the underlyin	g ceuse giv	en in Pert I.	23b. Did	tobacco use co	ontributa to	the cause of deat							
requires that the death ce been signed by the attendi hould be detached for use	y Physician/							1 🗆	Yes 2□ No	3 Prob	ably 💯 Unkno							
been s should	pleted b	pieted by	pleted by	pleted by	Completed by	pleted by	pleted by	pleted by								en eutopsy omed?	com	re autopsy findings ileble prior to pletion of cause leeth?
The law	Ö							10	Yes 2 No	10	Yas 2□ No							
E 15 0	Be	25. Wes case referred to medicel exeminer?					26. Plece of D	eeth (Check only	one)									
\$ 00	၉	1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/O	utpetient 3	DOA Oth	er: 4 Nursing	Home 5 Resi	dence 6 Ott	her (Specify))							
After thi funeral		27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Injur Wor		28d. Describe	how Injury occu	rred								
i or Attanding effer death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				199 Z [] NO	281. Location (Street and Number or Rural Route Number, City or Town, State)											
# to - X /		29a. Certifier (Check only one) Certifying Phy 2 Madical Exam	rsician: To the best of iner: On the basis of and manner stat	exeminetion er	e, death occurr nd/or Investiget	ed et the tin	ne, dete and pleo plnion, death occ	ce, end due to the curred et the time,	ceuse(s) end m dete end pleca,	anner es ste end due to	eted. the ceuse(s)							
Funeral etely filled	5		and mailler stat			29c I Irens	e number		29d. Date signe	ed (Month D	lau Vaari							
the Hospital ithin 24 hours o the Funeral ompletely filled	-	29b. Signeture and title of certifier					/ 4 * / 1 4		Date eight	THE EXPLICATION AND								
1000	-	29b. Signeture and title of certifier					00-		40 = 1									
To the Hospital within 24 hours to the Fugeral I completely filled	Σ	1 Day				RES	- 000		NP.P.	1911	1998							
To the Hopita within 24 hours To the Fuperal Completely filled	Σ	29b. Signeture and title of certifier 30. Neme en (some some of person who c	completed cause of de	eth (Item 23e)	(Type, Print)	RES	-000 1 Hos	pial	ARRIN Boltin	1911								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month ADRIL OXT 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Me ari 119 imore If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth Month, Pay 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** -32-Months 1938 1□ M 2 KF Days Yrs Director 119 Usuel Residence of Decedent 10e. State 10b. County 10c. City Town or Location 10d. Inside City Limits Maryland the Medical Examiner must be notified 1 Yes 2 No Director IMOTR 10e. Street end Number 10f. Zip Code 10g. Citizen ot Whet Country? 7a d Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Applity: Can þ 3 Widowed 4 □ Divorced mer ican Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) traumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Son important: If item 27 is any injury or other trau 1d.2 20b. Plece of Disposition (Neme of cemetery, cremetory or other) x ton TO. 20e. Method ot Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremetion 3 Removel from Stete Eternal 4 ☐ Donetion 5 ☐ Other (Specify) Garden ot 21. Signature of Funeral Service-License 22. Name end Address of Facility JOSeiph L. Ky oseph Bal Hom W. North Ave. ter the drauge, or complice for's that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, heart finding. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel FARUNE CONGESTIVE HEMET Unavous diseese or condition resulting in deeth) Examiner Due to (or as e consequence ot): Physician/Medical Examiner Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence ot): Due to (or es e consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEIZURE b 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) STELLA MARIS AT MERCY Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA

the burial-transit thet the death certificete be axecuted P.O. Box 68760, signed by the et d be deteched for Records, The law requires page 2 certificate Vital ö 岩 After Division Attending

Director

nin 24 hours

B

the Meryland

Baltimore, Maryland 21215-0020

CROXTON, IDA

6 Items 23s

"natural", or

and Mental Hygiena.

1 and 2 should be

Health

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE

28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Yes 2 No

Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end menner es stated.

28e. Pleca of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier Comons

5 Pending Investigation

6 Could not be determined

D40480

29c. License number

29d. Date signed (Month, Dey, Year) 19, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) FERRO FERNANDO

RD 7672 SELMIK BACTO

State Registrar

31. Dete filed (Month, Day, Year)

27. Manner of Deeth

1 Neturel

2 Accident

4 Homicide

3 Suicide

29a. Certifier

32. Registrar's Signeture was Davidson

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** dam Month April 4:50 AM wreton 1998 /Medical 4b. City, Town, or Location of Deeth BALTIMORE 4e. Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner CHURCH HOME HOSPITAL If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth MAYOR, 129 Year 1912 ROPETH CAROL. 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 219-03-6851A 15M 20F 85 Yrs. Director NA Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner mast be notified as 10d. Inside City Limits N/A MARYLAND BALTIMORE 1 Yes 2□No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1403 CARSWELL ST. 21218 u.s.a. 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. 11. Maritel Status 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: ģ Specify. NEGRO 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) RAILROAD/BETH STEEL Elementary/Secondery (0-12) 8 TH College (1-4or 5+) LABORER Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be UNKNOWN UNKNOWN 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) THELMA JENNINGS/CARETAKER1403 CARSWELL STREET BALTO, MD. 21218 20b. Place of Disposition (Name of cemetery, cremetory or other place)

Voshell Mem. Darden Apr. 21, 1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Ponetion 5 □ Other (Specify) 22. Name end Address of Fecility
CALVIN B. SCRUGGS FUNERAL HOME e of Funeral Service Licensee 1412 E. PRESTON STREET, BALTO, Fert 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause of each line. MD.21213 Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, þ ate hes been sig pege 2 should b 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy this certificate hes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28c. Injury et Work? 28b. Time of Certification: 28d. Describe how injury occurred Naturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) by 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as steted.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. (Check only 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) . M. 1. 30. Name end eddress of person who completed cause of death (Item 23e) (Type Print) Ldolf

State Registrar 31. Dete filed (Month, Day, Year)

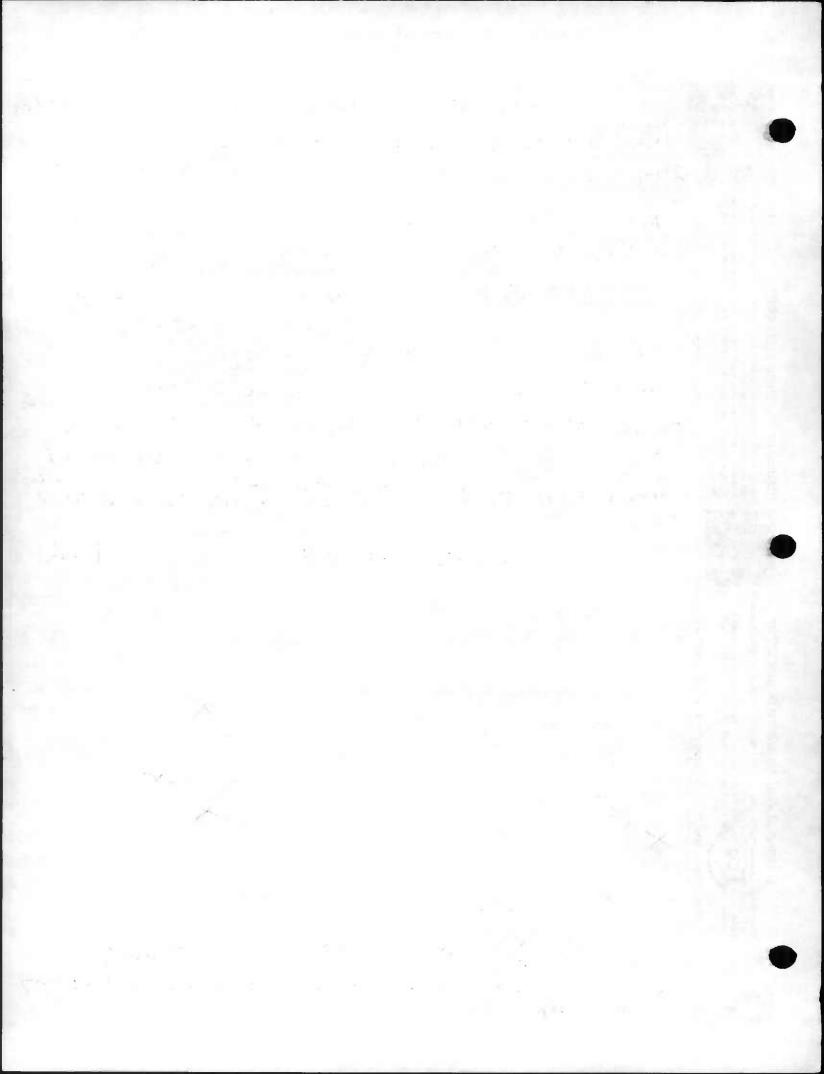
i, m.0 32 registrary Signeture Randolfe St. L. Mars English, Edited to the St. Co. 195, that

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 2506

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Caldwel 4:40 A.M 18, 1998 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number Examiner Street Baltmore
If Under 1 Year If Under 24 Hrs. 8. Date OSSath 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 15 M 2□ F Months Days Hours 68 219-10-3463 Usuel Residence of Decedent Yrs. Ma 5 29 Director with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itan 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Expension must be notified at NA Baltimore 1 Yes 2 No Director 40 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 144 . Kossutt permit. Pages 1 end 2 should be filed within 72 hours efter death. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Merried altimore, Maryland 21215-0020 1□ Yes 25 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed Baltimore County Board of Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Education Service Building 9th grade Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Caldwel eda 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore ud Caldwell-Wite reet Kossuth 20b. Placa of Disposition (Name of gemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) any injury or o rowsuille, Cen -22-98 rownsville Va 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21215 F. H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, Ket Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner hysician end the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): infsten of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as a consequence of): 98 use (signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2□ No 3 Probably 4 ☐ Unknown O Yes 2 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? hes pege 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate director. 25. Was case referred medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 8 Other (Specify) To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA fungial 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how Injury occurred 27, Manner of Death 28b. Time of Certification: Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my optnion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the th 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 035601 use of death (Item 23e) (Type, Print) 30. Neme end eddress of person who com-DASP PR # tur Outerby MPL grosse SAMUR 31. Date filed (MC Registrer's Signature State Registrar

DHMH 16 Rev 6/95



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Baltimore,	of He land		20e. Method of Disposition **Dauriel 2 Cremetion 3 4 Donetion 5 Other (Spec		9	v, crema	tion (Name of atory or other pl s Mem			Balti														
Balt	permit. Page Depertment of Important: if any Injury or		21. Signature of Funeral Service Lic	B. Cap	-	55		nner Avei		timor		d. 21215												
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Be Complete Medical Certification: To

2 Accident 3 Suicide Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined Plece of Injury - At hon building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. S

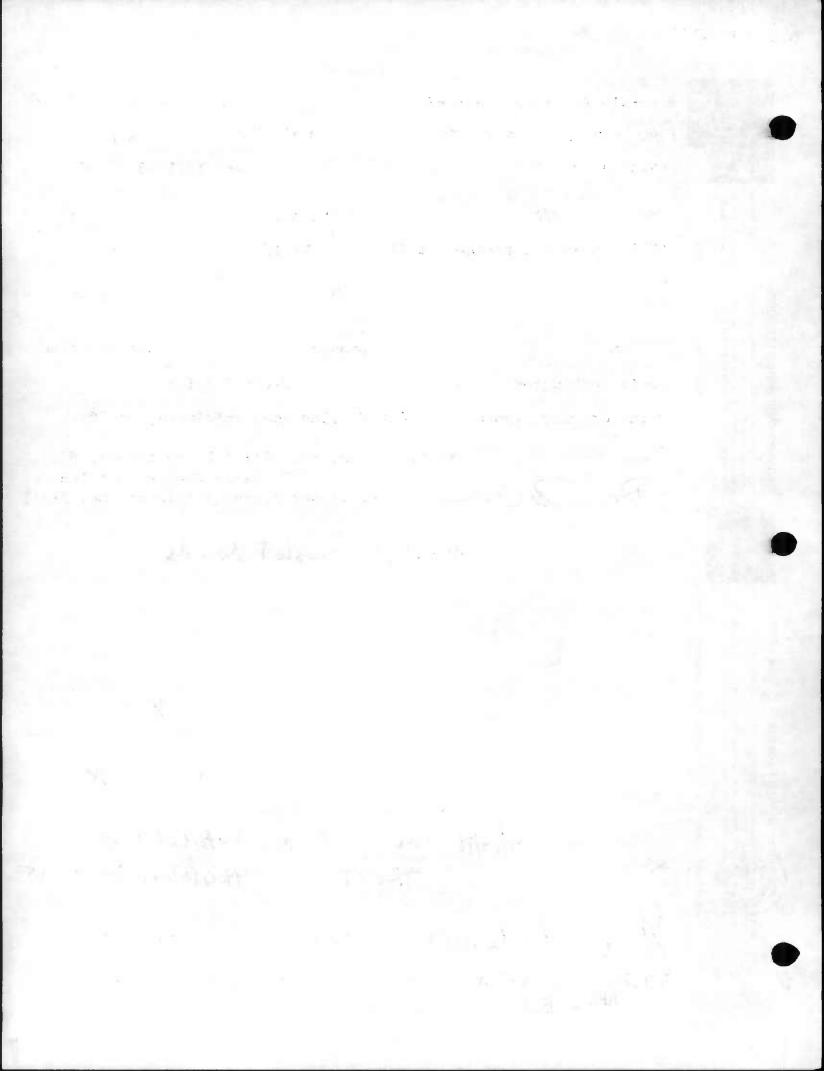
29c. Licensa number O.C.M.E.

29d. Data signed (Month, Dey, Year) APRIL 15, 1998

pleted cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** GLORIA COHEN APRIL 16 1998 10:32 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6607 CHELWOOD RD. BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1□M 2♥F 216-20-8836 Yrs. 70 DEC. 4, 1927 Director MARYLAND Usual Residenca of Decedent the Marylend 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mapical Examinar must be notified at MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6607 CHELWOOD RD. 21209 USA 2 should be filed within 72 hours after deeth and Mental Hygiene. Is marked other than "netural", or items 23. Funeral 14. Race - American Indien. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: WHITE à Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be RALPH **EPSTEIN** RUTH **SMEZLESKY** To 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Department of Health and Important: If item 27 is n eny injury or other traun MITCHELL COHEN (SON) 12 STRAW HILL CT. OWINGS MILLS, MD 21117 Baltimore, 20b. Placa of Disposition (Neme of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI 4/19/1998 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service L SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease shock, or heart failure. complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death one cause on each line **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Bud Box 68760. attending physicisc Physician/Medicai the to (or es e consequence of) 80 USB signed by the a 23b. Did tobecco use contribute to the cause of deeth? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PO 1 Yss 2₽No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peeu completion of cause of death? hes 1 ☐ Yes 2 I No 1 Yes 2 No Division of Vital I director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidenca 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident ofter death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours 8 24 hours e 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner as steted. Medical completely Examfner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner steted. To the I 29b. Signature and til 29c. License number 29d. Date signed (Month, Dey, Year) 0

State Registrar

32 Registrar's Signature

cause of death (Item 23a) (Type

State of Maryland / Department of Health and Mental Hygiene 9

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tion		1 Naturel 5 Pending 2 Accident Investig	(Mon	th, Dey Year)		М	8c. Inj W 1[ork? ⊒Yes 2□] No				
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Certification:		4 Hottiicide	buildi	ng, etc. <i>(Sp</i> a	city)					City or 10	own, Stete)		
edicai (29a. Certifier 1 Certifying	Physician: To the xaminer: On the ba	best of my k	nowledge, dec	oth occurred	at the	time, dete e	nd plece,	and due to the	ceuse(s) end m	anner as s	tated.
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2		29b. Signature and little of certifier	/ //	1.	Mr. A			nse number	0		29d. Date sign		
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Joseph A Courto Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Them:8 per F.H.G-759 5/1/98 reb

Cottificate of Death Certificate of Death Reg. No. per FH G758 4/21/98 EW A Month 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death **Physician** Russell Gardon Carr /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4e Facility Nema (If not institution, giva straat and numbar) Examiner enter " BALTIMORE KOSe If Undar 24 Hrs. FRANKLIN SOMARE HOSPITAL SEDALE 8. Data of Birth 1921 (Month, Day, Yaar) June 13, 1920 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax **Funeral** Days 1 M 2 F Yrs 216-12-6470 Baltimore, Maryland Director Usuel Rasidance of Dacedant filed within 72 hours efter deeth with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yas 2 No Director Baltimore Maryland Baltimore County 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21236 LISA 3900 Klausmier Road Funeral 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 12. Wes Dacedant Evar in U,S. Armed Forcas? 11 Marital Status 1 Navar Marriad 2 Married 1 Yas 2004 1 Yas 2 No Specify: à 3 Widowad 4 Divorced Year or Dates: WWII White Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elamantery/Secondery (0-12) 12 Technical Illustrator U.S. Navy Yard Pages 1 end 2 should be filed vent of Heelth end Mental Hygid int: If item 27 is marked other f 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Gordon Carr Laura Wall 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) 4204 Mary Avenue Baltimore, Maryland 21206 Kathleen A. Hichew (Daughter) 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata Data 20a. Mathod of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Gardens of Faith April 17,1998 Baltimore, Maryland 21. Signature of Funarai Sarvice Licensaa 22. Nama and Addrass of Facility Lassahn Funeral Home, Inc. e-or complications that causad the death. Do not antar the mode of dying, such as cardial List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 ntar tha mode of dying, such as cardiac or respiratory arrast, **Physician** ardial Infarction /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, if eny, leeding to immediate causa. Enter Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consaguanca of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? Mollitus 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings availabla prior to completion of ceuse of daath? 24a. Was an autopsy Completed After this certificate has funeral director, page 2. 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was cesa rafarrad to medicel axaminar? 26. Place of Daath (Chack only ona) 1 ☐ Yas No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Dete of Injury (Month, Day Yaar) 28d. Dascriba how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Panding efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No invastigation 3 ☐ Suicida 6 Could not be datermined 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Spacify) 4 - Homicida 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar es steled.

Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and menner stated. To the Hospi within 24 hou To the Funer completely fil edical 29a, Certifier 29b. Signeture end title of certifiar 29c. Licansa number 29d. Data signed (Month, Dav. Year) parson who completed causa of deeth (Item 23e) (Type, Print) 9000 FRANKLIN Square BALTO MD 21237

Registrar

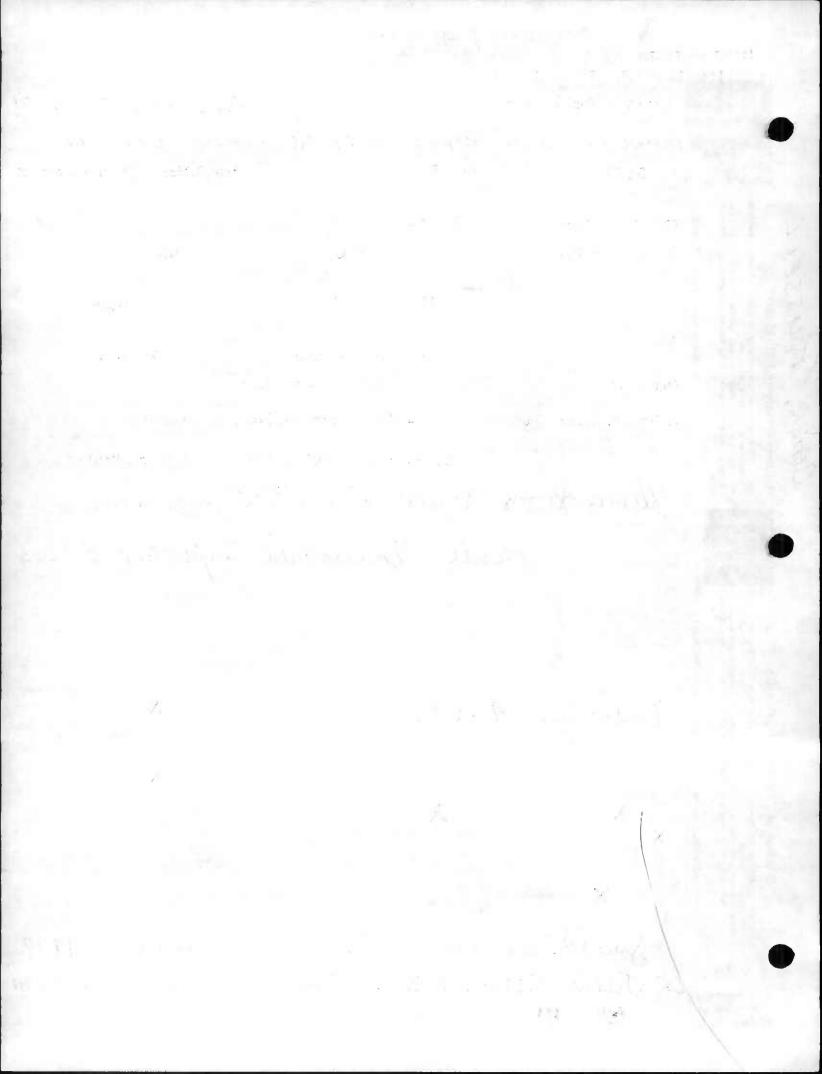
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32. Ragistrar's Signatura

Mulia Davidson-Randall

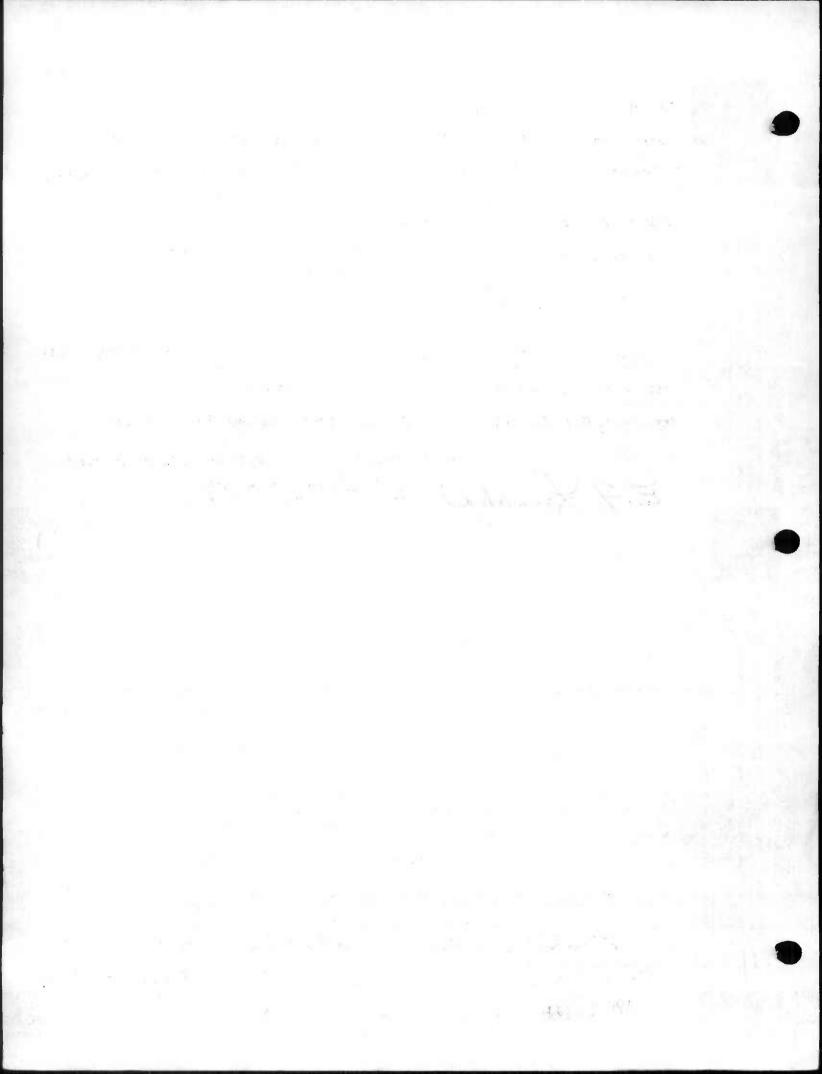
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Leanore April 1998 9:35 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health of Forest Hill Forest Hill Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 1 □ M 2 X F Months Days Yrs. 065-32-8513 Director 89 Nov. 10,1908 Depew, New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
int: If them 27 is marked other than "natural", or trems 23a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 20 No Director Maryland | Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11902 Cedar Lane 21087 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 10 yrs. Clerk Buffalo General Hospital n/a 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Decatur Siegert Ellen Ann Murray 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) int of Health e I: If Item 27 is 7 or other train Mrs.Jeanne Gay (Niece) 11902 Cedar Lane Kingsville, Md. 21087 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/15/98 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home Kingsville, Md. 21087 11750 Belair Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician caldiovascular disease /Medical immediete Cause (Finei disease or condition resulting in deeth) **Examiner** Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effect death.

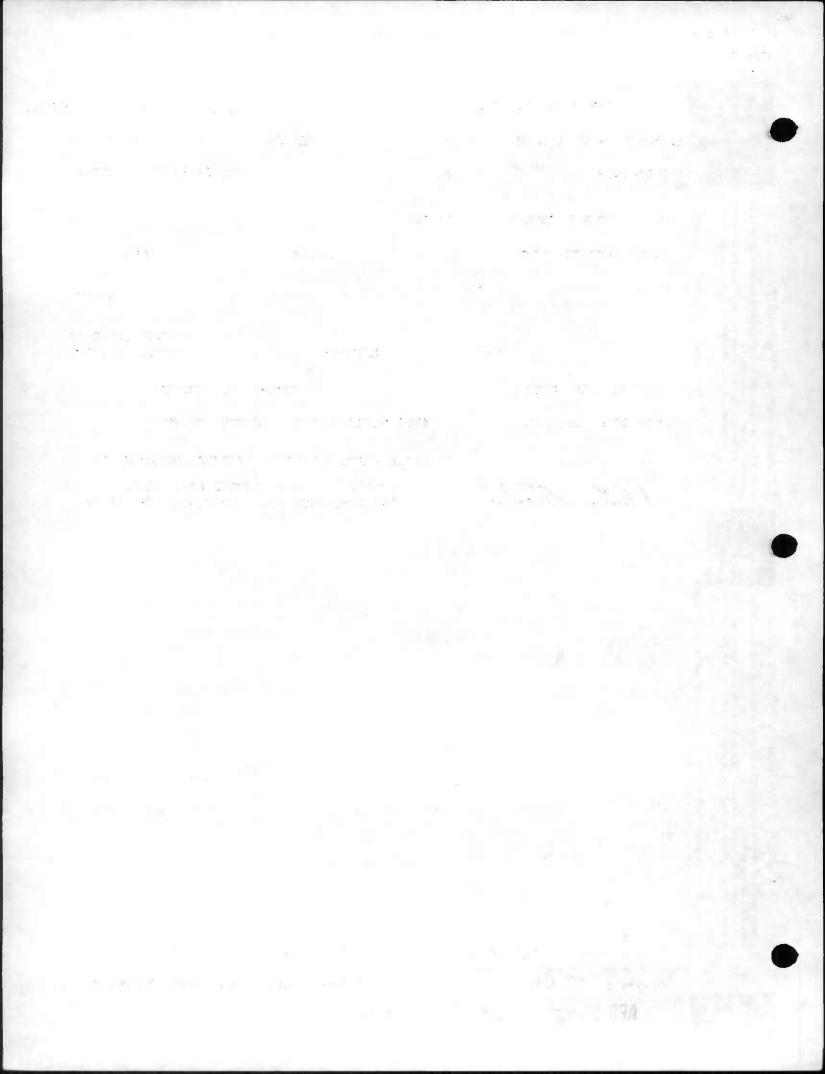
To the Fueral Director: After this certificate hes been signed by the ettending physician encompletely filled in by the funcation of the property of the proper Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detec 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilebie prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 → No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 2 Other: 4 → Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturei 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) d35522 30. Neme and address of person who completed cause of death (item 23a) (Type, Print) Bel Air Maryland North Arenne 31. Dete filed (Month 32. Registrar's Signeture State whia Davidson Registrar



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State Registrar Jennis J. C.
31. Dete filed (Month, Day, Year)
APR 21 1998

32. Degistrar's Signature



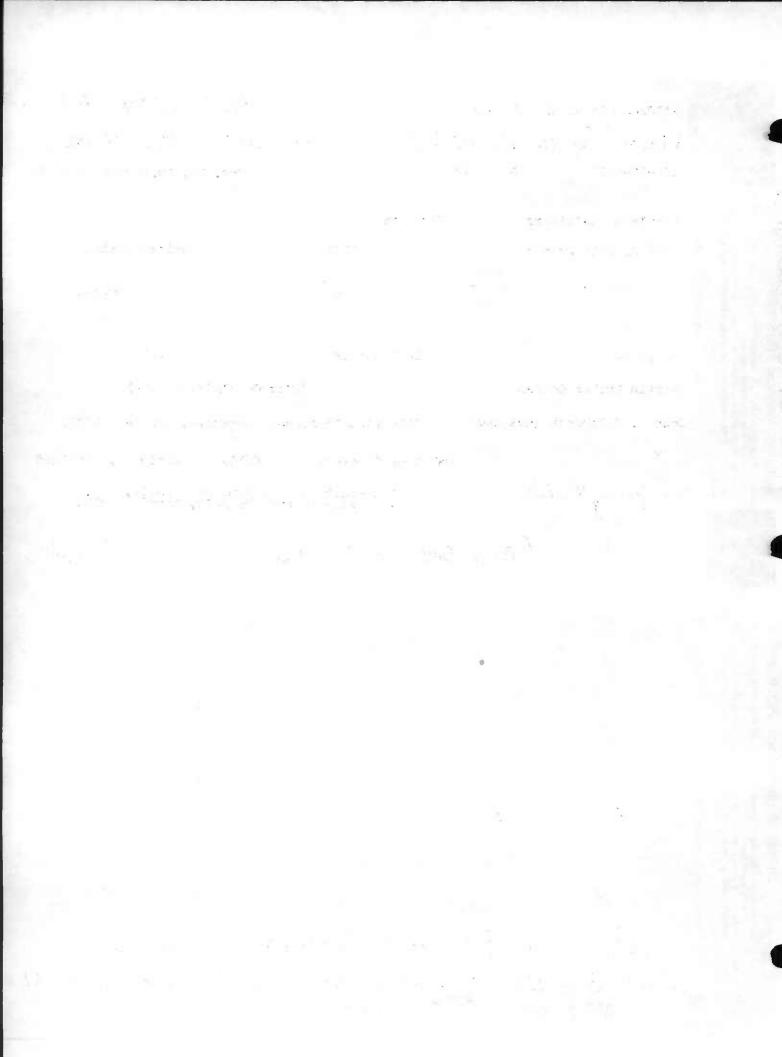
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25/3 Certificate of Death Reg. No. 3. Time of Deeth 2. Data of Deeth 1. Decedent's Nama (First, Middle, Last) **Physician** pm 12:10 HOLL Mildred Elizabeth Calebaugh /Medical on of Death 4b. City, Town, or Local County of Deeth 4a Eacility Name (If not institution, give street end number) Examiner Mare timore MAKIN Birthplece (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 6 SAY **Funeral** Months Devs Hours 1 ☐ M 25 F 72 233-36-8412 12, 1925 West Virginia Director Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits 10e State 10b Counts 1 ☐ Yes 2 ☑ No Director Edgemere Maryland Baltimore å 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code must be n 21219 United States 2216 Lincoln Avenue TO. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Wes Decedant Evar In U,S. Armed Forcas? 14. Race - American Indian, 11 Marital Status "natural", or iten Black, White, etc. 1 Yes 2 No
If Yes, Giva
Yeer or Detes: 1 ☐ Navar Married 2 X Merried 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Stee1 12 years Steel Worker 17. Fether's Neme (First. Middle, Last) 18 Mother's Name (First, Middle, Meiden Sumeme) 89 Pages 1 and 2 should be Montal Martin Luther Conrad Gertrude Elmira Hamrick 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) John R. Calebaugh (Husband) Edgemere, Maryland 21219 2216 Lincoln Avenue Item 27 altimore. 20b. Place of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 6 cemetery, cremetory or other place) 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Oak Lawn Cemetery 4/18/98 Baltimore, Maryland 21. Signeture of Funerel Service License 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Avenue Dundalk, Maryland

23e. Pett. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Inc. d 21222 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner nding physician and use as the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate per Physician/Medical Dua to (or as a consequenca of) signed by the ail Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy has le 2 i certificate has 1 Yes 2□ No 2 No Hospital or Attending Physician: director. 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Death Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Neturel 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funeral Director: A completely filled in by the f 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Tertifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

Z Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29e. Certifier edical (Check only one) the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 30. Name end eddress of person

State Registrar

31. Data filed (Month

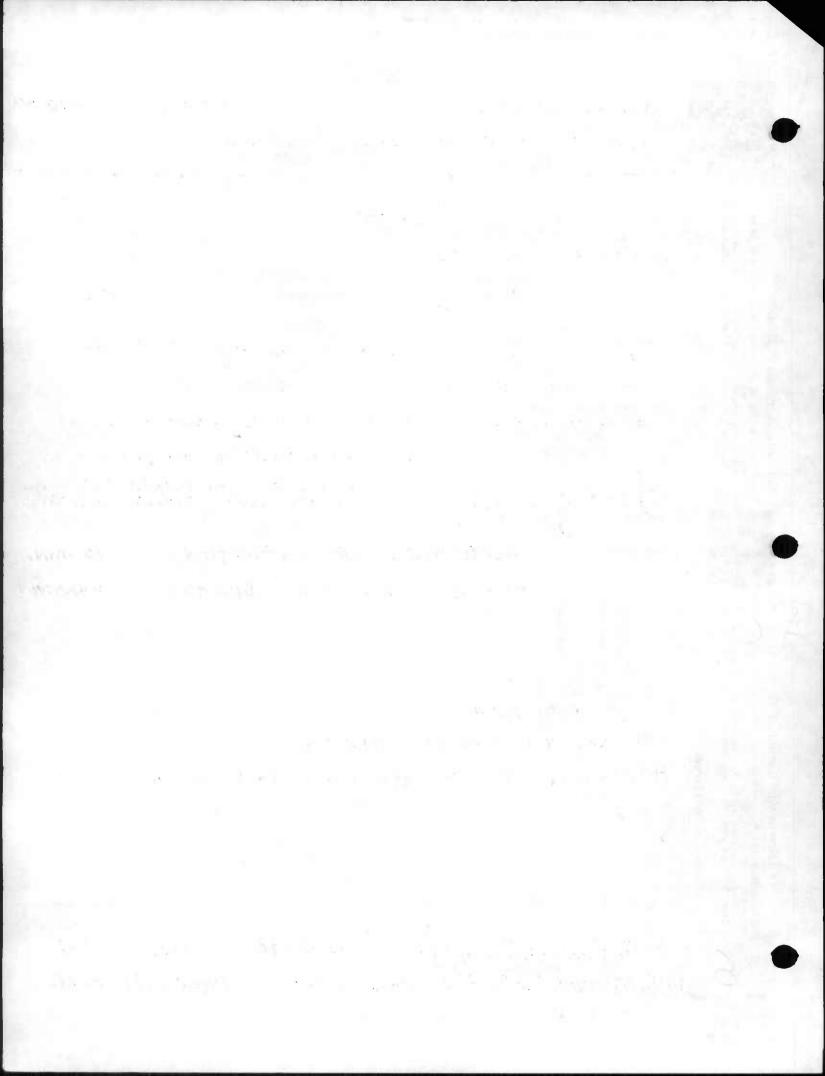


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedant's Neme /First Middle Last 2. Data of Death 3. Time of Death **Physician** 6:10 AM LEROY O. DYETT, SR. APRIL 16, 1998 /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 3024 AUCHENTOROLY TERRACE (res.) N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months) Deys Hours Min. 07/19/19/28 9. Birthplaca (State or Foreign Country) Iew York City 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 217-24-2316 69 New Director Usual Rasidanca of Dacadant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerting Frust be marked. 10e, State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No N/A BALTIMORE Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 3024 AUCHENTOROLY TERRACE 21217 U.S.A. Funeral 12. Was Dacedant Evar in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian. Bleck, White, atc. 1 X Yas 2 No5/3/51 If Yes, Giva Yaar or Dates: 6/4/53 1 Naver Married 2 Married 1 ☐ Yas 2X No Specify: Black ģ 3€ Widowad 4 Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) 16a, Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elemantary/Sacondary (0-12) Collaga (1-4or 5+) Funeral Home Entrepreneur/Mortician 12th 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middle, Last) James Marcus Dyett, Sr. Marion Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Leroy O. Dyett, Jr. 8505 Charlton Road, Baltimore, MD 21133 20b. Place of Disposition (Nema of cematary, crematory or other place) Date 24 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Garrison Forest Vet. Cem/. Owings Mills, MD 4 Donetion 5 Other (Specify) 21. Signetura of Funarai Sarvica Licansa 22. Name and Addrass of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 Rand. Enter the disease, of complications that caused, a death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line Approximata tritarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final ACUTE MYOCARDIAL INFARCTION 15 MIN. disaasa or conditior rasulting in daath) Examiner Physician/Medical Examiner ARTERIOSCLEROTIC HEART DISEASE UNKNOWN Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting in death) Last Due to (or es e consaquence of): Dua to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert i. 23b. Did tobacco usa contributa to the cause of death? HYPERLIPIDEMIA 1 Yes 2 No 3 Probably 4 Unknown þ NON-INSULIN DEPENDENT DIABETES 24b. Were autopsy findings eveileble prior to completion of causa of death? 24a. Wes en autopsy performed? Completed HYPERTENSIVE CARDIOVASCULAR DISFASE 1 Yas 2 No 1 Yas 20 No certificate Division of Vital 25. Was casa rafarrad to medical axaminar? 89 26. Pleca of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 27. Mannar of Death 28a. Deta of injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 Naturel Attending 5 Pending invastigation 1 Tyes 2 No 2 Accidant after deat Director: 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide n 24 hou. * Funeral Dir-titled / ò Certifying Physician: To the bast of my knowladga, daath occurred at tha time, date end place, end due to tha cause(s) and manner es stated.

| Medical Examiner: On the bast of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) end manner stated, 29a. Certifier Medical (Check only To the within 2 To the I attending 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifian and addrass of person who completed cause of death (Item 23e) (Type, Print) 2300 GARRISON BLVD. BALTIMORE, MD. 21216 M.D.

State Registrar 32. Registrar's Signatura

kilia Davidson Randall



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** John 18:05 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) -34-Months Deys Hours 217-34-6926 Usual Residence of Decedent 1 M 2□ F Yrs. Director 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23s or 28s-f show Medical Examiner must be notified at the Manyla 1 Yes 2 No Funeral Director more Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of Whet Country? Vei 21 deathy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American I Black, White, etc. American Indian 11. Marital Stefus ours ather 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be lilled within 5 Department of Heelth and Mental Hygens. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Is marked other traumatic event, t 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumeme) Be O 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) (wite ,21237 vonne 10 20b. Plece of Disposition (Neme of cometery, crematory or other plece) 20a. Method of Disposition pete 20c. Location - City or Town, Stete Important: If its any injury or o once. 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2 rar 21. Signature of Funeral Service/Licer Ave 5 W. North 21216 long or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, form. List only one ceuse on each line. Approximate tntervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician end s the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): 89 esn esn for 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was an eutopsy performed? Completed is certificate has director, pege 2 : 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yea 27 No 27. Menner of Death 1 Kinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No deeth. 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 24 hours effer 4 C Homicide Hospital for Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier edical (Check only one) To the Withing 29b. Signature and title of certifier

State Registrar

31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed ceuse of death (item 23a) (Type, Print)

600 North Wolf 32. Registrar's Signature hie Davidson

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Diambinov 1998 **Physician** April Vera /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Yeer 9. Birthplace (State or Foreign Country)
Sofia, Balgaria 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 200 F Days Hours 158-26-0718 70 Yrs. January 1,1928 Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Heelth and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified anonce. 1 Yes 2 No Jackson County Directo UCW JOSEN C Occan 10f. Zip Code 10g. Citizen of What Country? USA Road 983 08527 Funeral 14. Race - Americen Indian, Black, White, etc. 11. Maritel Status Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Mongolian by 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Scamstress 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Be San ji Iva 19a. Informent's Neme/Retationship (Type, Print) Saha Amar hanow LvanchuKov 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -ydia Moschkin / Daughter 10123 Thornwood Rd. Kensington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremetion 3 Memovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Apri 22,198) a St. Vladinirs 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Gary P. March 230 Fredhilton 1955 Baltimore, Maryland 21229

23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximate Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Myocardial Infarction 40min Examiner Coronary Artery Examiner Oyears ettending physician end for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of). Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? Ventricular Tachycardic arrest Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evalleble prior to completion of cause of death? Chronic Renal Insufficiency 24e. Was en eutopsy performed? Diabetes Mellitus 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural
2 Accident 5 Pending investigation 24 hours after death.

Funeral Director: Af 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical To the I 29d. Date signed (Month, Dey, Year) 29b. Signature and Jitle of certifier 29c. License number RES-000 moer MD

Tower 110- Johns Hopkins Hospital

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

John Tavidson Randalle

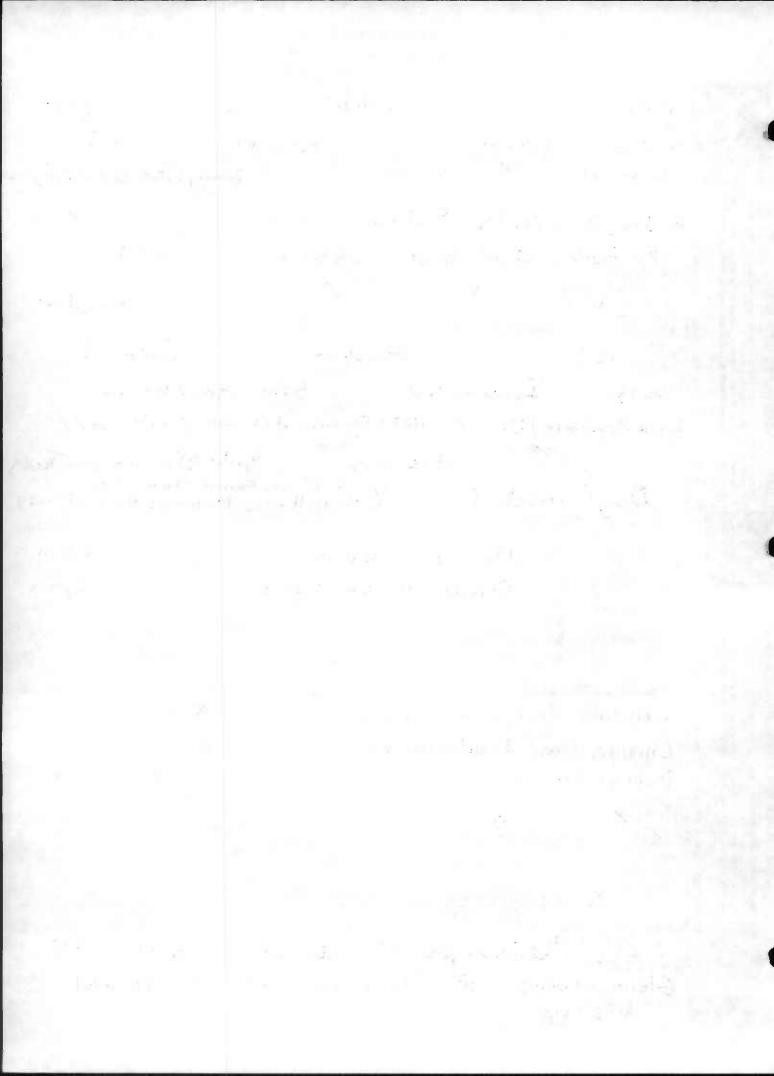
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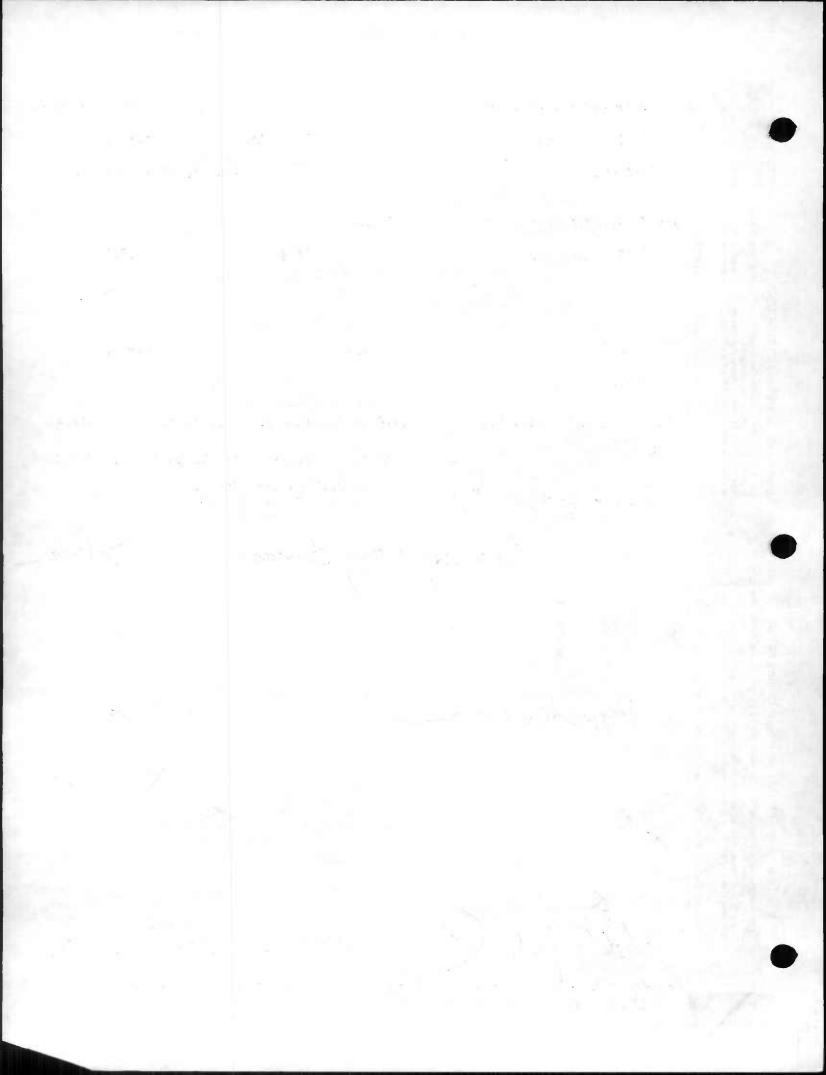
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State of Maryland / Department of Health and Mental	Hygiene
Cortificate of Dooth)

	Decedent's Name (First, Middle, Last)	Cen	tificate of Death	2. Date of Deat	eg. No.	3. Time of Death
Physician /Medical	Agnes Marie Esserwe			April	18, 1998	9:30 AM
Examiner	4e Fecility Name (If not institution, give street end.) 4419 Carlyn Road	wn, or Location of Death y Hall	4c. County of Death Baltimor			
Funeral Director	5. Sociel Security Number 6. Sex 1 □ M 2 ★ F	7. Age (In yrs. lest birthdey).	If Under 1 Year if Under Months Days Hours			lace (Stete or Foreig try) Land
pus A	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		1	0d. inside City Limit
Maryle f sho	Maryland Baltimore		erry Hall			1 ☐ Yes 2 🛣 No
rect	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Coun	itry?
th with	4419 Carlyn Road		21128		U.S.A.	
ed within 72 hours after death with the Maryland yegens. yegens. t, the Medical Examinar mant be notified. Completed by Funeral Director	1 Never Married 2 Married 1 Yes	s 2 No	As Decedent of Hispanic Ori Yes, specify Cuban, Mexican Yes 2X No Specify:	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Rece - Americ Black, White, Specify: Whi	etc.
n 72 hours naturel', out et Ex	15. Decedent's Education (Specify only highest grede complete	16a. Deced	ent's Usual Occupation ind of work done during mos O NOT use retired)	at of working	16b. Kind of Business/Inc	dustry
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Mental H Mental H arked oth artic even	Vernon Meekins		Mar		Tohnson	
2 should land Men ls marke eumatic	19a. informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street end Number	er or Rurel Route Number	, City or Town, Stete, Zip	Code)
Health a Health a Health a Sther tree	Nancy Ann Judy (daugh	iter) 471	O Ilkley Moor	Lane, Ellic	cott City, MI	21043
of He of He roth	20a. Method of Disposition	20b. Piece of Dispos cemetery, crem	ition (Neme of etory or other place)	Date	20c. Location - City or To	wn, Stete
Page nent int: if	1 □XBurial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	Gardens o	f Faith Cemet	ery 4/21/98	Baltimore,	Maryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygera. Important: If item 27 is marked other than any injury or other treumatic event, the Moce. To Be Compi	21. Signature of Funeral Service Licenses	Dry 22.	Name and Address of Facili Schimunek Fun 9705 Belair R	eral Homes, d., Baltimor	Inc. 1e, MD 2123	36
Physician /Medical Examiner	immediate Cause (Final disease or condition resulting in death)	Due to (oras a consequ	try dise	ruse	>	1 year
loate be executed physician and a the burlal-transit edloai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ				
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detant The certificate rector, pag	25. Was case referred to medical examiner?		Othor	e of Death (Check only on		
After this After this funeral d	27, Manner of Deeth 28a. De	□ Inpatient 2□ ER/Outpatient ste of injury lonth, Dey Year) 28b. Time of Injury	28c. injury at Work? M 1 Yes 2	28d. Describe ho	ence 6 Other (Special ow injury occurred	⁽ y)
To the Hospital or Attending P within 24 hours fairer death completely filled in by the tuner completely filled in by the tuner. Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ace of Injury - At home, farm, stre ilding, etc. (Specify)	pet, factory, office	28f. Location (Si City or Town	treet end Number or Run n, Stete)	al Route Number,
Heaptan 24 hours Funeral etaly filled dlcal C	(Check only Medical Examinar: On the	the best of my knowledge, death besis of examination and/or inv anner stand				
within y	290. Signature and title of certifier		29c. License number	LA CA	9d Date signed (Month,	Dey, Year)
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A=5 1250	30. Name and eddress of person who completed or	ause of dealin (Itam 23a) (Type 1	Print)	CA.	F -	0
	30. Name and eddress of person the completed of	ause of deal 1 1 23a) (Type, i	Print) RI Rd. Br	1 Pio mo	21015	

Registrar



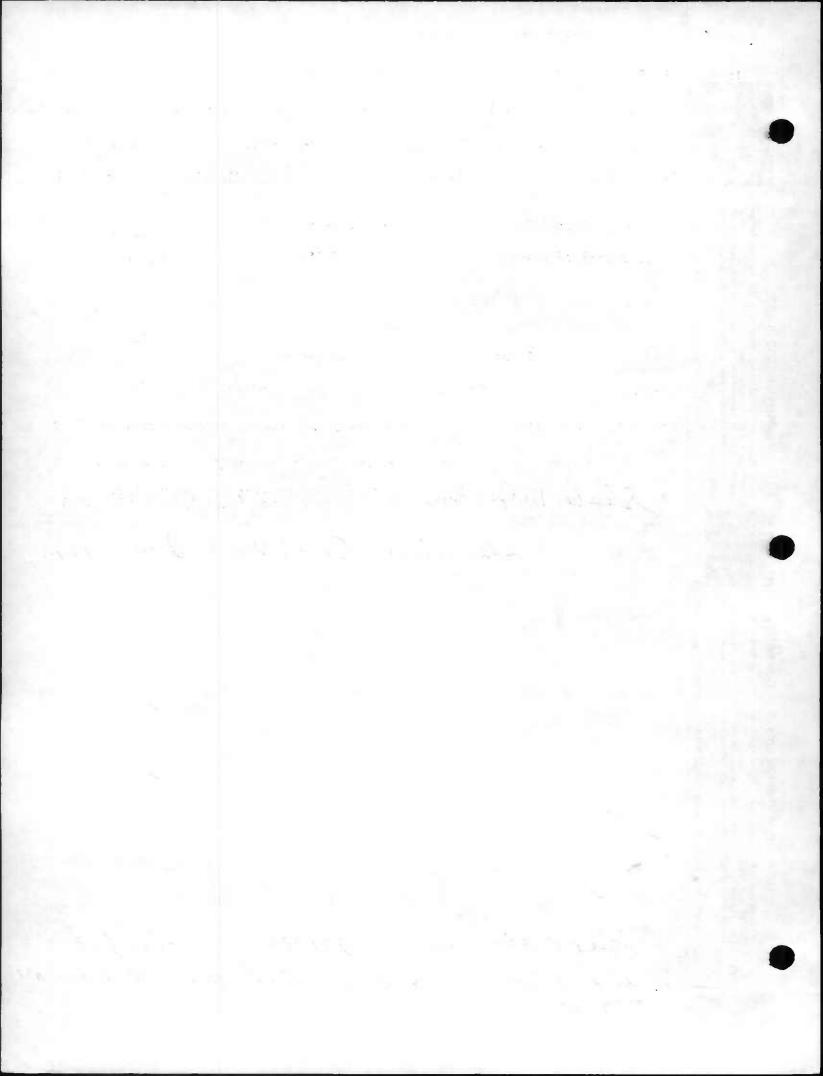
Item	#19	State of Maryland / Department of Health and Mental Hygiene 9a per FH G763 9/1/98 EW Certificate of Death Reg. No.									
Physicia /Medica		1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day Year 7:00 An									
Funeral Director	er	4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Daath 508 CameLot Drive 5. Social Sacurity Number 212-01-4080 4c. County of Death Harford 8 Bel Air Harford 9. Birthplaca (Stata or Foreign Months) Months Days Hours Min. June 29, 1920 Maryland									
show		Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits									
ith the Ma or 28a-f s	Directo	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country?									
Fe, Maryland ZIZIS-UUZU 1 end 2 should be filed within 72 hours efter death with the Marylend 1 Health and Mental Hygiene. 1 tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	508 CameLot Drive 11. Marital Status 1 Navar Marriad 1 Navar Marriad 3 Widowed 1 Divorced 1 Navar Marriad 1 Navar Marr									
id X IX IS-0020 filed within 72 hours ef Hygiene. ther than "netural", or ent, tra Medical Exert	Completed	15. Decadant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Coilega (1-4or 5+) 160. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) Foreman 16b. Kind of Businass/Industry Meat Company									
Maryland ZIZ d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, tra M	To Be Co	Be	Be	o Re	0 26	17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Everett S. Edmonston 19a Informant's Name/Belationship (Type Print) 19b Meiling Address (Street and Number of Rural Boutle Number City of Town State Tip Code)					
Deficiency, Mayon Definitely, Mayon Department of Health an Important: if Item 27 is any Injury or other trau		Sarah J. Phelps (Wife) 20a. Method of Disposition 1 \(\text{Denation} \) 3 \(\text{Ramoval from Stata} \) 4 \(\text{Donation} \) 5 \(\text{Othar (Specify)} \) 3. Neiling Address (Strata at Nation A table Nation of Nation									
permit. Pages 1 Department of H Important: if lie any injury or ot		21. Signatura of Funaral Sarvica Licansaa 22. Nama and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014									
ficate be physicials the bur	Ir/Medical Examiner	23a. Part1. Enter the diseasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, Approximate interval Batween Onset end Death Immediate Cause (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Ceusa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of):									
es that the death igned by the atte	mpleted by Physician/M	þ	þ		þ						Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Tunknown
The law require ate has been sig pege 2 should t						Cerebral Vascolar Accident 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death?					
trending Physician: death. ctor: After this certific y the funeral director.	10 DE	25. Wes casa referred to medical examinar? Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No									
Hoapi Hoapi Funer tely fill	edicai	29a. Certifier (Check only one) 29a Certifier (Check only one) 17 Certifying Phyalcian: To the best of my knowledge, death occurred at tha time, deta and place, and dua to tha cause(s) end mannar es stated. 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha time, date and place, end dua to tha causa(s) and manner statad.									
To the within To the comple	E.	29b. Signetura and titla of certiliar Lobert Lobert Lobert 29c. Licansa number 29d. Date signed (Month, Dey, Year)									
State	9	30 Name end eddress of person who completed cause of death (Itam 23a) (Type, Print) Robert S. Kuight, M.D. 104 Pluntrec Rd. Stc 102 Bel Air, M.D. 21015 31. Data filad (Month Prop. great) 1998 32. Ragistrar's Signature Andree									

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grant many and the contract of all this against a latter of the transfer of the transfer to the state of the state

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Item#8 per FH G758 4/28/98 EW Reg. No." 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Yaar **Physician** Ede1 1998 7:30 April 17, p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Golden Crest Senior Group Home Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 StF Months Days Yrs. Director 213-46-2981 New York 11/04/16 Usual Residence of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 21 No Directo Maryland Carroll Westminster 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 118 Fairfield Avenue 21158 U.S.A. Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 2∑No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Intercrant: If flem 27 is marked other than "natural", or iten any injury or other traumatic event. The standard of the Black, Whita, atc. 1 □ Nevar Marriad 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: à 3 N Widowed 4 □ Divorced White Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Mt Wilson Elementary/Secondary (0-12) College (1-4or 5+) State Hospital 2 Years Secretary 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Stalder Hilda Smith George 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Samuel Kim Edel (Son) 2100 Brookmead Court Reisterstown, MD 21136 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 € Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) Mt Olive U.M. Church Cem. 4/21 Randallstown, MD 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licansee Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD Lenkens 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** Corony Voicela Dise-12 Atherosaleratio /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and the burial-transit that the death certificete be executed Sequentially list conditions, if any, laading to Immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of). 88 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Division of Vital Records, P 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy peeu completion of causa of death? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Attending Physician: funeral director, 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Be Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending or Attending efter death. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicida Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within £4 hours elements To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifier (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) US. Mon, MA 114 Business Canda Oirs Reinfard, Md 0 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) C. Moss 06-1-7 32 Registrate Signature Funda Dandon - handa M. Day Yaar) 1998 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gordon Charles Ewers Apri /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) Examiner ROSE if Under 24 Hrs. Baltimore FRANKLIN 5. Social Security Number P. Age (In yrs. last birthday) enter da Saylare If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□ F Min. 72 Yrs. Baltimore Co., Md. Director 220-12-4601 28,1925 Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore County Directo Maryland 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4604 Charles Avenue Funeral 12. Was Decedent Ever in U,S Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, Whita, etc. 2 should be filled within 72 hours efter and Mental Hygiene. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Nevar Married 2 ☑ Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White WW II Completed 15. Decedent's Educetion (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementery/Secondary (0-12) Self Employed Excavating Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eva Mitchling Charles Ewers Peges 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health mportant: If item 27 4604 Charles Avenue Baltimore, Maryland 21206 Gladys L. Ewers (Wife) altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of N Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith April 18, 1998 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Lassahn Funeral Home, Inc. lications that caused the death. Do not couse on each line 7401 Belair Road Baltimore, Maryland 21236-4625 Pall 1. Enter the diseal , or complications that caused the shock, or heart failure. List only one ceuse on each line Approximate Interval Between Onset and Deeth Do not enter the mode of dying, such as cerdiac or respiratory arrast, **Physician** Immediate Cause (Finel disaese or condition resulting in death) /Medical CardioVascular Disease · arterioselerotic Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, laading to immadiata ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate per Box 68760 Due to (or as a consequenca of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 2 No Physician: 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending investigation death. 1 Tes 2 No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 | Homicide within 24 hours of To the Funeral Di completely filled it 1 🗷 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. edicai 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only 29b. Signatura moulle of certifian 29c. License number 29d. Data signed (Month, Day, Year)

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Birat's Simature Randelle

9000 FRanklin Square DR Baltimore, Md 21237

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

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APR 21 1998

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31. Date tiled (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: item #20b PenrFH Film G758 4-21-98RC Reg. No. 3 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month **Physician** 6:40A) FARO DHN 04 19 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Co. Glen Burnie Millenium Health and Rehab. Center If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Jan 12 7. Age (In yrs. last birthday) 85 Yrs. 9. Birthplace (Stata or Foreign 6. Sax **Funeral** T913 1XM 20 F Months 212-10-7783 Maryland Jan. **Director** Usual Rasidanca of Daceden the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, the Medical Examinat must be nor if the 1 Vas 2 □ No Directo Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21230 USA 1428 Battery Ave. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Never Merried 2 Married 1 Yas 2 No It Yas, Give Yaar or Datas: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Ship Fitter 18 Mother's Name (First Middle Maiden Sumama 17. Fathar's Nama (First, Middla, Last) Be Vincenza Rena Joseph Faro 19b. Malling Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) 1089 Crest View Drive Annapolis, Md. 21401 Joyce Murphy (Daughter) 20b. Placa of Disposition (Nama of cematary, cramatory or other place) April 1998 Brooklyn Park, Md. 20a. Method of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval trom Stata 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signeture at Funeral Service Licensea ²² Name and Address of Facility McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230 ancel 23a. Pen1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death **Physician** "Atheroselestic Cardiovas wher Disease Immediate Ceuse (Final disease or condition rasulting in death) /Medical 15413 Examiner Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Disease or Injury thet initiated avants rasulting in death) Last Dua to (or as a consequança ot) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consaquance of) 980 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 thiknown Wellows - Type I ğ 24b. Wara autopsy tindings available prior to 24e. Was an autopsy Completed Dementia complation of causa of death? page 2 1 Tyas 2 No certificase 25. Was case reterred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 THO 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA 番 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. tnjury al Work? 28d. Dascribe how Injury occurred Certification: Hospital or Attending P
 S4 hours after death.
 Funaral Director: After I Affler 5 Panding invastigation 1 Netural 1 ☐ Yas 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, tactory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours a Puneral C 1 Certifying Phyatclan: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) end mennar es stated.
2 Medical Examinar: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar edical (Check only one) To the 1 within 2 To the 9 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura end titla of certifiar 39660 0 Nama and addrass of person who completed cause of death (Itam 23a) (Typa, Print)

State Registra

31. Data filad (Month, Day, Year) APR 2 1 1998

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Lest) Sylvia 06 **Physician** rields 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Liberty Medical Center **Baltimore** n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month Day, Year) 9. Birthplace (State of Country)
11/10/1952 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 20 F 45 Yrs. 214-62-5615 Director Usual Residence of Decedant with the Meryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after deeth with the Merylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show reumstic event, or Medical Exacting mail by recting a n/a 1 X Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2863 W. North Avenue 21216 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind at work done during most of working lifa. DO NOT use retired) Blue Cross/Blue Elemantary/Secondary (0-12) Collega (1-4or 5+) Secretary Shield 12th permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eugene Thomas Lillie Anthony 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Edgewood Avenue, Balto., MD Lillie Liggons 20b. Place of Disposition (Nama of cemetery, crematory or other place) 4/20/98 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
LEROY O. DYETT 21. Signature of Funeral Service Licens & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 Figure the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each the Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final diseese or condition resulting In death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? ed by the detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by i 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy lindings available prior to complation ol cause of death? 24a. Was an autopsy Completed peeu

Division of Vital Records, P.O. Box 68760 The law requires that the death certificate

i certificate has b director. this funeral Aftert death.

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Certification:

or Attending Physician: within 24 hours after death To the Funeral Director: A completely filled in by the f Hospital

State

31. Date filed (Month, Day, Year) APR 21 1998 Registrar

25. Was case referred to medical examiner?

1 Yes 2 No

27. Menner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Cartifian

4 Homicide

(Check only one)

55a

5 Panding invastigation

6 Could not be detarmined

Hospital:

1 DInpatient

28a. Date of Injury (Month, Day Year)

29c. Licensa number

28c. Injury et Work?

1 Tes 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

1 Yes

2 1 No

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28. Place of Death (Check only one)

1600 W. MOUNT Rojal Ave, Balto 30. Nama end addrass of person who completed cause of death (Itam 23a) (Type, Pript) SALVIA DA DAKSHAN 5. M

1V certifying Physicien: To tha best of my knowladga, daath occurred et tha tima, data and place, and dua to tha causa(s) and mannar as steted.

2 Medical Exeminer: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

2 ER/Outpatient 3 DOA

28b Time of

28e. Pleca ol Injury - At home, ferm, street, lactory, office building, etc. (Specify)

32. Registrar's Signature he Deviden

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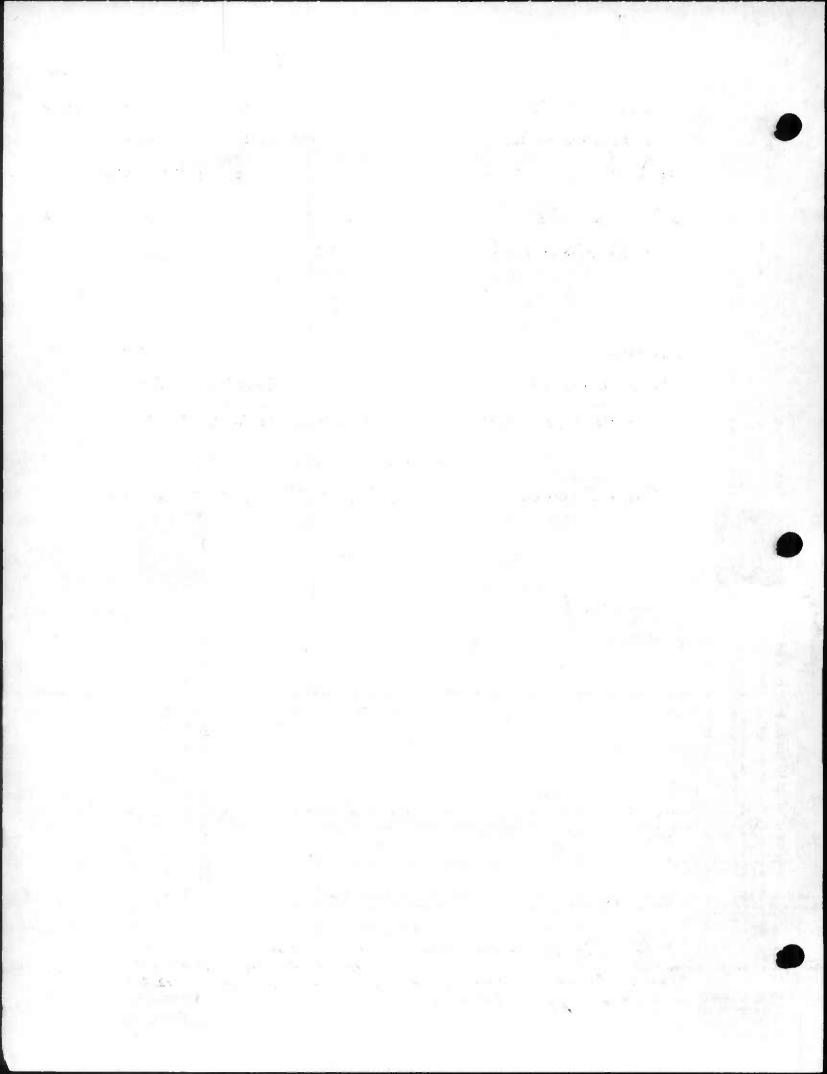
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death **Physician** Month Edith R. Fowler 1998 April 12:10 PM /Medicai 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Perry Hall 9018 Cowenton Avenue Baltimore | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Min. | Oct. 28, 1909 5. Social Security Numbar 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplece (Stete or Foreign 1 □ M 2 X F Mary Land 213-20-3111 88 Yrs. Director Usual Residence of Deceden the Maryland 10e, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23e or 28a-f shiner must be notified Maryland Baltimore Perry Hall Director 1 Yas 2 No 10e. Straet end Number 10f. Zip Code 10g. Citizan of What Country? 9018 Cowenton Avenue 21128 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11. Marital Status 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married 21215-0020 ò 1 Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Homemaker Own Home other Maryland 17. Fethar's Neme (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if flem Z7 is marked oth any Injury or other traumatic event any Injury or other traumatic event 18. Mother's Name (First, Middle, Meiden Surneme) Be Peter Ruckelshaus Wilhelmina Schmidt 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Fowler Biscoe (dghtr) 8226 Edwill Ave., Baltimore, MD 21237 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20c. Locetion - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata Gardens of Faith Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 4/18/98 Baltimore, Maryland 21. Signature of Funerel Service Licensae 22. Name and Address of Fecility Schimunek Funeral Home, Inc. Duan a. Wellen 9705 Belair Rd., Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final . Hypertensine disease or condition resulting in deeth) **Examiner** The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Stenosis þ 24b. Were eutopsy findings evelleble prior to completion of ceusa of deeth? Be Completed breast cancer in 1991 certificate has been 1 ☐ Yes 2 No 1 ☐ Yes 2 No ivision of Vital Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Neturel 5 Pending Investigation Attentila 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homleide within 24 hours a To the Funeral C completely filled the Hospital Medical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Desupande MD D 46082 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NEETA DESTIPANDE, M. D 9105 FRANKLIN SQUAREDR. BALTIMORE, MD 21237

32. Aggistrer's Signature Randall

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Mary) Day,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey April 18, 1998 9:15 a.m. Fred Monroe Forshey, Jr. 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) 5593 Broadwater Lane Howard Clarksville | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Days Hours Min. | Min. | Dec. 29, 1948 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 1 M 2□F 49 Yrs. Pennsylvania 203-38-1878 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Clarksville Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5593 Broadwater Lane 21029 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1XXYes 2 □ No If Yes, Give Yeer or Detes: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married Married 1 ☐ Yes 2 K No Specify: Specify. White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elamantary/Secondary (0-12) Dept. of Defense Intelligence Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude M. Lavell Fred Monroe Forshey 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Anne J. Forshey/Wife 5593 Broadwater Lane, Clarksville, Maryland 21029 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition KXBurial A Cremation 3 Removel from State Maryland Veterans Cem. 4/24 Crownsville, Maryland 5 Cmer Spec 4 Donation 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, but only one cause on each line. Approximate interval Between Onset end Deeth & Respiratory Failure Immediate Causa (Final disease or condition resulting in death) 242-1 Dua to (or as a consequence of) 4-88-47 Aspiration PARUMenia Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequance of): Rectal Adenousining Dua to (or es a consaquenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anorexia / Lachexia Ureteral obstruction, 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Chronic animia 1 Yes 2 No 1 ☐ Yes 2 No 25. Was casa raferred to medical examiner? 26. Place of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Dey Year) 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No investigation

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

4-21-98

29d. Date signed (Month, Dey, Year)

signed by the e

and I-transit physician ar dimetor, page 2 s

Physician

/Medical

Examiner

Directo

Funeral

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylai Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any Injury or other traumatic event, the Medical Examiner must be notified at page.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Be

edicai Certification: To

2 Accidant

3 ☐ Suicide

29a. Certifie

4 Homicida

29b. Signeture end title of certifier

The lew requires that the death certificate be executed sion of Vital Records, P.O. Box 68760, # After Bulgu

State

DHMH 16 Rev 6/95

address of person who complated cause of death (Itam 23a) (Type, Print) MINEUR are

2 Know Worth 32 Registrar's Signature

Mn.

28e. Placa of Injury - At home, ferm, straet, factory, office building, atc. (Specify)

To the best of my knowledga, death occurred at tha time, date and placa, end dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the causa(s) and manner stated.

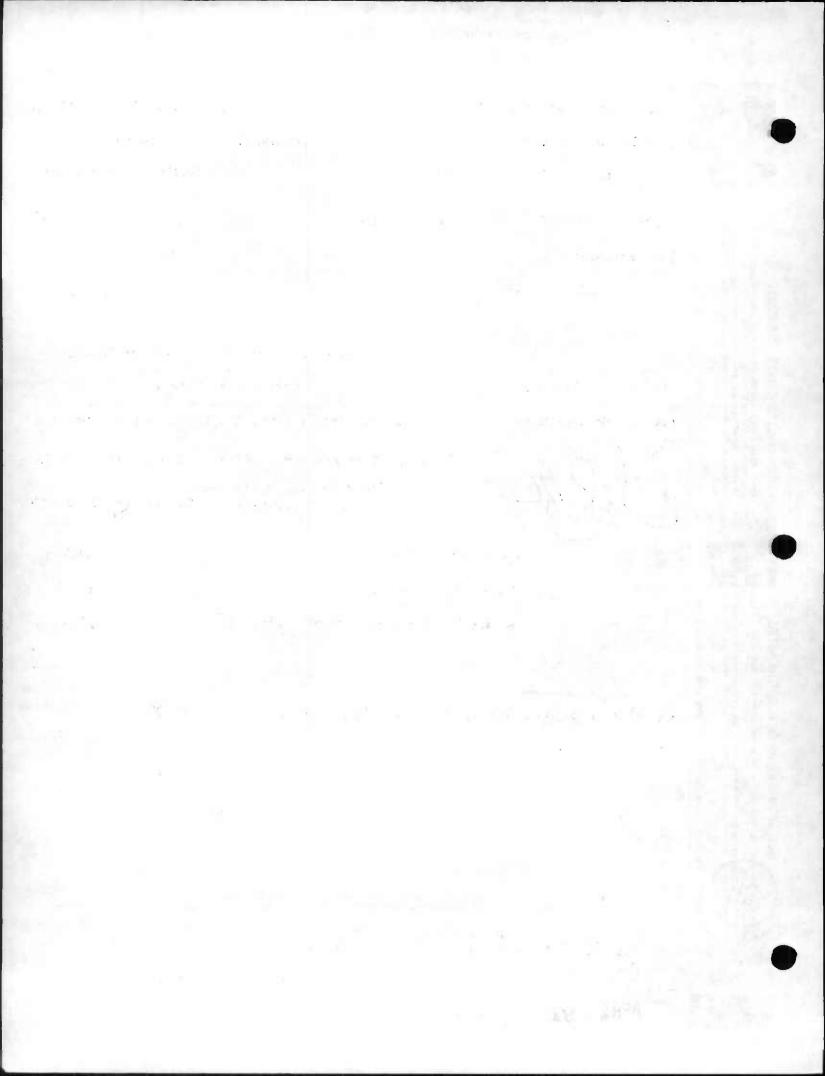
29c. License number

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Colombia MD 21045

31. Date filed (Mooth, Dey, Year)

6 Could not be



State of Maryland / Department of Health and Mental Hygiene

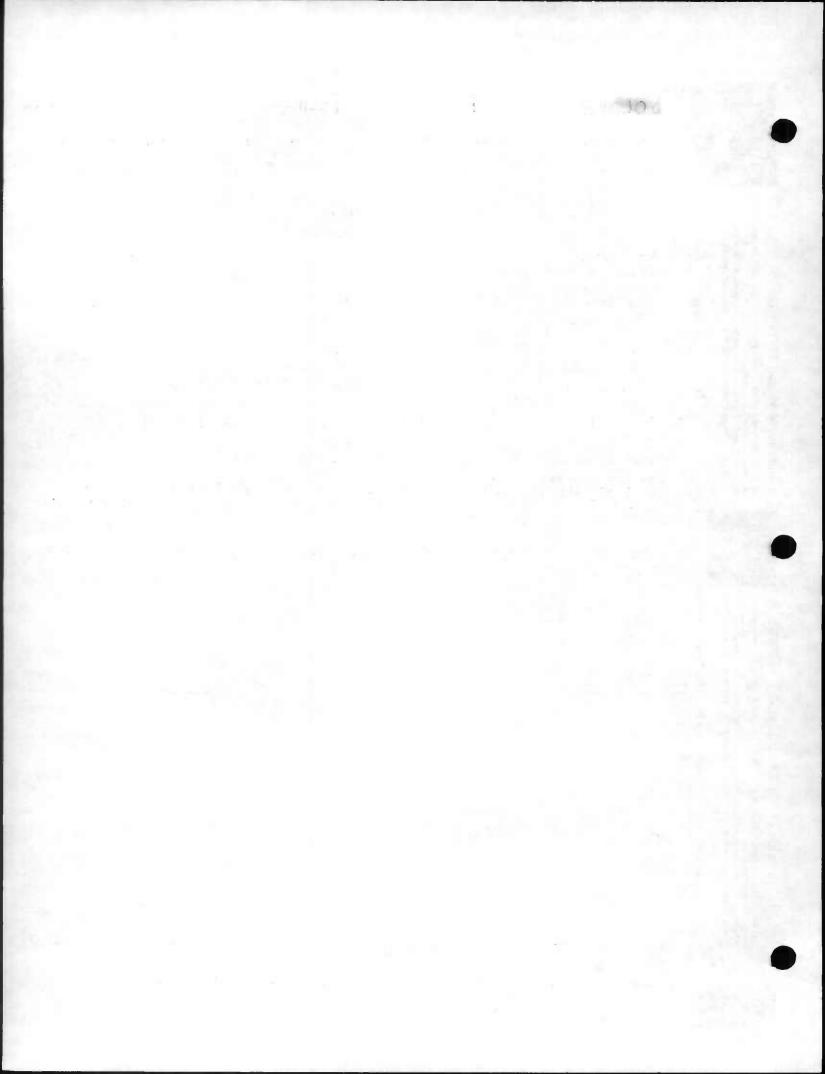
Certificate of Death Reg. No. 3. Time of Deeth 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** STANFORD **FOLUS** APRIL 17, 1998 2:30 AM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3710 VALLEY HILL DR. RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** X□M 2□ F Months Deys 212-24-7712 70 Yrs. MAY 12, 1927 Director MARYLAND Usuel Rasidence of Decedent with the Maryland r 28a-f show a notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MARYLAND Directo BALTIMORE RANDALLSTOWN 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mentel Hygiena. Important: If Item 27 is merked other than "natural", or items 23a or in any highry or other traumetic event, the Medical Examiner must be an enter. 3710 VALLEY HILL DR. 21133 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yas, Give X Yeer or Detes: 1 ☐ Yes 2 🖾 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) RESEARCHER MEDICAL EQUIPMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be PHILLIP **FOLUS** JENNY **GOLOMB** 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) HARRIET FOLUS (WIFE) 3710 VALLEY HILL DR. RANDALLSTOWN, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State BETH TFILOH 4/19/98 5 ☐ Other (Specify) BALTIMORE, MD 4 Donation 22. Name end Address of Fecility 23a. Part Enter the disease, or complication shock, or heart feilure. List only one ceus SOL LEVINSON & BROS., INC. cation the faused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate to course of sech line. Intervel Between Onset end Daeth **Physician** immedlete Ceuse (Final disease or condition resulting in deeth) /Medical e ALUle Examiner MYOCOPAINI INTUNCTION Due to (or es e consequence of): Physician/Medical Examiner FSChenic Cornomyonethy attending physicials and for use as the burial-transit the deeth certificate be gracuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): A.S LLES X signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, by should b 24b. Wara autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifical completaly filled in by the funeral director, 25. Wes case refarred to medical Be 26. Pleca of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 70 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicida 12 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and mannar stated. edical 29a. Cartifian (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number / leen 029085 ca MID April 17 1998 30. Neme and eddress of person who completed causa of deeth (Item 23e) (Typa, Print) Allan J. Chircus M. D 5310 OID COURT Ruces 21133 31. Dete filed (Month, Dey, Yaar) 32. Registrer's Signeture State APR 21 1998 Sulia Davida Registrar mark.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 1678 **Physician** 11.45 M DOLDRES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Yrs. 213-30-2131 66 Director FEB 13, 1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Menial hygiena. Important: If Hem 27 is marked other than "natural" or the specimal of the manual of the speciments of 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Millersville 1 Yes 3 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 562 Lanny Court 21108 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Enich Dorsch Ellen Anderson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 562 Lanny Ct. Millersville, MD 21108 Earl James Folmer/husband 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Metro Crematory, Inc. 4/17/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu eral Service Licer 22. Name and Address of Facility Dawn F. McDonald Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applishock, or heart failure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death Physician /Medical Immediete Ceuse (Finel diseese or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DUSTINE 44ETTA **Examiner** Due to (or as a consequenca of): Examiner physician and that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequença of): Box 68760, Physician/Medical Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed hes 1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Yas 2 No 1.2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: To the Hospital or Attending I within 24 hours after death.

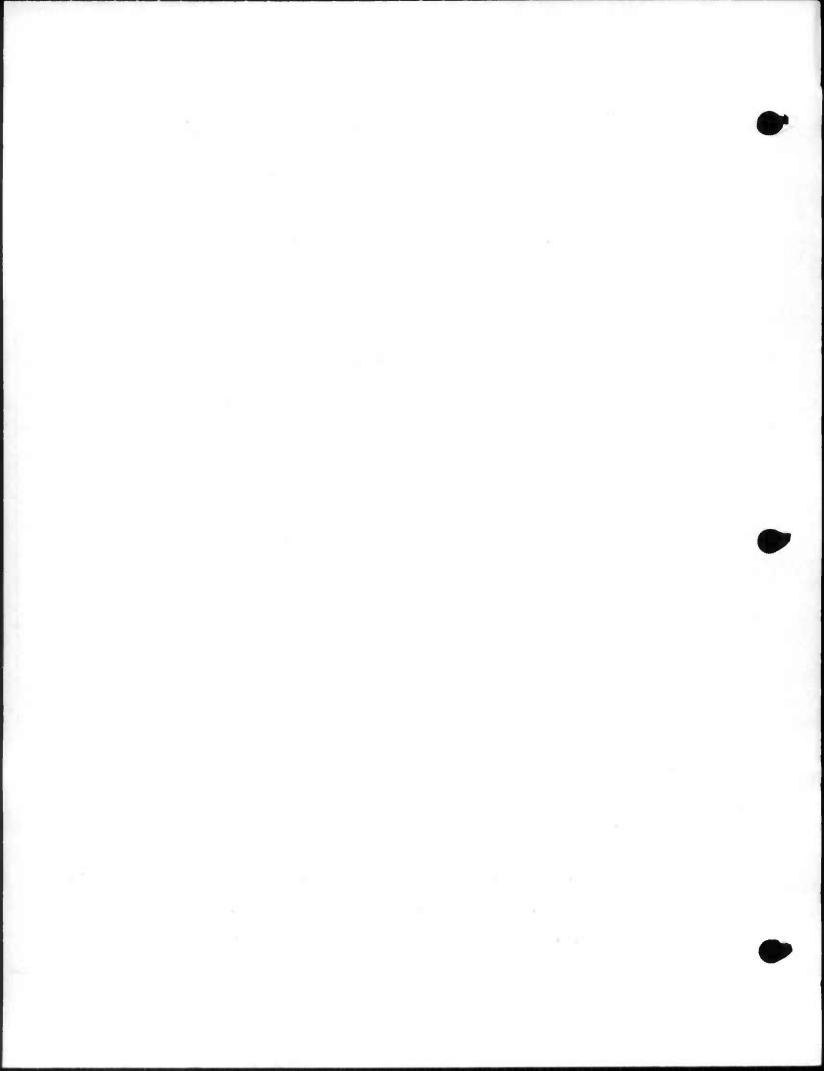
To the Funeral Director: After 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifies MEMCHE BOTTOM D005 227 D, 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) ATTROGRE, THE NORTH ARUNDEL HOSPITAL FRANCIS KW A3HIE 31. Dete filed (Month, Dey, Year) 32) Registrar's Signeture APR 21 1998 the lander Registrar



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		1. DECEDENT'S NAME (First, Middle, Last)	s F. Flo	WETS	Sr.		2. DATE OF	F DEATH DAY	2	3.	TIME OF D	AL M
should		4. SOCIAL SECURITY NUMBER 220-09-9208 90. FACILITY NAME (If not institution, give st	1 😿 M 2 🗆 F	(In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	April	BIRTH Day, Year) 30,1915		Country)		or Fareign
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Pages	FUNERAL DIREC	10a. STATE 10b. COUNTY	ngton		ry, town or local Hancock	TION				1122	d. INSIDE C LIMITS?	
n. ansit permit.		100. STREET AND NUMBER 4022 Resley Road	0		10	21.750			10g. CITIZE	N OF WHAT	COUNTRY	Y7
5-0020 nding physician. as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	if yes, sp	CENDENT OF HISPAI becify Cuben, Mexics 2 XNO Specif	in, Puerto Ric	(Specify Yes o	Yes or No— 14. RACE — American Black, White, etc. Specify: White			indian,
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TARYL rtained by t should be utified at	BE	John Flowers 19e. INFORMANT'S NAME (Type/Print)				Jenny	Brady	7				
be ret	2	Mildred Flowers		4022 1	Resley Re	and Number or Rural				ide)		
I IMORE I. Page 6 may ral director, pag		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State com	etery compton or	OF DISPOSITION (Ne other place)		DATE	1	ATION — CIT	,	State	
Page 6 m of director,		21. SIGNATURE OF FUNERAL SERVICE LIG	FIGER / IST	Paul's	Lutheral 22, NAME AI	ND ADDRESS OF FA	4/16/9	8 Han	cock,	_MD_	_	
SAL r death re fune al.		1 Luchan	Mother	N	/ 141 W	Funeral	Stron	t Uan	cock	MD 5	21.750	⊢ ∩368
bours after of in by the or removal		23. PART I. Enter the diseases, or or ahock, or heart failure.	omplications that caused list only one cause on e	the death. Do	not enter the mo	de of dying, suc	h aa cardia	c or respire	etory arres	t,	Approx	
4 = 5 0		IMMEDIATE CAUSE (Final disease or condition resulting in death)	sme	U (ell	long	Cane	cr					and Death
OX 68/60 exe excited within 2 sician and completely f rior to wintal, crematio traumatic event, th	NO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
D/ # 15 5 E	ICATION											
th certification of other officers	CERTIFIC	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										
at the de by the a and Men Wen y Injury	AL	PART II. Other algnificant conditions	contributing to death be	ut not resulting	in the underlying	g cause given in	Part I. 2	4a. WAS AN A PERFORM			RE AUTOPS	
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4 9 9 5	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:							
SICIAN: The certificate in the State	PHYS	27. MANNER OF DEATH	1 Inpetient 2 ER/Outp	26b. TIN	E OF 26c, INJ	URY AT		Specify)	IURY OCCUE	PED .		
After this death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1 .	PRK? YES 2 NO						
ATTENDI CTOR: A after de 28 is	G	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY building, atc. (Speci	— At home, ferm,	stree1, factory, offic	•	28f. LOCATI City or	ION (Street an Town, State)	d Number or	Rural Route	Number,	
425	COMPLET		CIAN: To the best of my knowless: On the best of examination								d menner e	na stated.
TO THE HOSPI TO THE FUNER TO THE WITHIN	BE (29b. SIGNATURE AND TITLE OF CERTIFIER	m. 1	1 1-	2	29c, LICENSE NUN			29d. DATE S			er)
6 6 9 W	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type	Print)	041	667		7	14.	98	
/_		Michael J. Mil	Cormack 1	1110 m		my us #	130	Hase	sku	-,1	107	2/742
0		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SION		22							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** April 16, 1998 7:20 P.M. Angelo /Medical 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Genesis Multi Medical Center Baltimore Towson If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**) M 2□ F Months 81 Yrs 220-09-8308 August 25, 1916 Maryland Director Usuel Residence of Decedent the Marylend r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 Tyes 2 M No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mentel Hygiene.

The processing the many statement of the many of the many of the many injury or other traumatic event, the Mages in the many injury or other traumatic event, the Mages in the many injury or other traumatic event, the Mages in the many injury or other traumatic event, the Mages in the many injury or other traumatic event, the Mages in the Mages in the many injury or other traumatic event, the Mages in the Ma 8109 Bon Air Road 21234 United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ₭ Yes 2 □ No If Yes, Give Yeer or Detes: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Technical Sargeant United States Air Force 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Samuel Ferrara Mary Marianna Campo 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mrs. Santa DeShon Showacre, Sister 2922 Rosalie Avenue Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/21/98 4 ☐ Donetion 5 ☐ Other (Specify) Towson, Maryland Zavoyna 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mark T. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland ns thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, use on each line. 23a, Pert1. Enter the disease, or on shock, or heart failure. List on Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, that the death certificate be Due to (or as e consequenca of) 98 USB Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 Yes 2 No p 24b. Were eutopsy findings evailable prior to completion of cause of deeth? should 24e. Wes en eutopsy Completed certificate hes t lirector, pege 2 s 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director, 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated. within 24 hou To the Fune completely fi edical 2 Madical Examinar: On the besis of examinetion end/or investigetion, In my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and the of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 8 W 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Bowie, John W. M.D. 6800 York Road Baltimore, Md 32. Registra's Signature 31. Dete filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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						Cei	rtificati	e or i	Death			Reg. No.		Liu V Ing		
Physicia	_	1. Decedent's Name (First, Mid FREIDA	dle, Last)	F	FOULKE		13)				A PRIL		1998	3. Time of D 8:07		
/Medic * Examin	_	4a Facility Name (If not institut GREATER BA			DICAL C	EN	TER	4	TOWS		cation of Deet		ounty of Death LTIMOR	E		
Funeral Director		5. Social Security Number 215–14–0653 Usual Residence of Decedent	6. Sex 1 M 2 F	7. Ag	e (In yrs. last bir 76	thday) Yrs.	If Under Months	1 Year Deys	If Under a	Min.	8. Date of Bir (Month, De May 8,			olace (State or i ntry) yland	Foreign	
Meryland H ahow	tor	10a. State 10b. Coun	y timore		10c. City, Tow Edge									10d. Inside City		
th with the 23a or 28a	Funeral Director	10e. Street and Number 3111 Roger Ro	ad				10f. Zlp 212				10g. Citizen of What Country? United States					
d 2 should be filled within 72 hours effer death with the Meryland thend Mental Hygiene. 71 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Evaminer mant be notified. To Be Completed by Funeral Director.	þ	11. Meritel Status 1 Never Married 2X M 3 Widowed 4 Divorce	If Yes. Gi	rces? XD1			Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Origin, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)		Black, White,	Raca - American Indien, Black, White, etc. Pecify: White		
	mpieted	(Specify only high Elementery/Secondery (0-12	ent's Education nest grade completed) College (1-4or !	5+1			Usual Occupation of work done during most of working of use retired)		ing		6b. Kind of Business/Industry Own Home				
	Be	7 years 17. Father's Neme (First, Middle Eugene Norto)		Homemaker 18. Mother's Neme Margaret						me (First, Middle, Maiden Surname)						
permit. Peges 1 end: Department of Health Important: If Item 27 I any Injury or other tr			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other 21. Signeture of Tunanel Servi	(Specify)	£	Parkwo	py, cremod	Ceme Name an uda-R 922 W	ther place tery d Addre uck ise	ss of Facilit Funer Avenu	al H	Nome of	Pari	ation-City or T kville, alk, In yland 2	Maryla C. 1222 Approximate Interval Between	een
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			ATORY 1	FAI	LURE						1	Onset and De	eth	
certificate be riding physicals as the bur		Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es a consequence of):								NDROME						
es that the deeth igned by the etter be detached for u	y Physician	Part II. Other significant condi	tions contributing to d				nderlying c	ause giv	ren in Part I			Yes 2		to the causa of		
aw requir s been s 2 should	Completed by	Id rypat	ric Th	~OY	mbocyt		enic	R	pu	na		s an autops ormed?	a a	Vere autopsy fin vailable prior to ompletion of ca f deeth?		
The page		Chron	ic Ster	01	9 P	Le.			00.51	-15		Yes 2	P 0 1	□Yes 2□N	10	
sician: certifica director,	o Be	25. Was case referred to medi examiner?	Hospitel:	Innati	ant 2∏EB/O	itnation	nt 3 🗆 DC	Oth	OF:		h (Check only		□Other (Spec	ihr)		

To the Hospital or Attending Physic within 24 hours effer death.

To the Funeral Director: After this completely filled in by the funeral directions. Division of

Certification: 1

ledicai

29c. License number D19401

28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

lor como

28a. Date of Injury (Month, Day Year)

6569 North Charles St., Suite 502 Towson, Maryland 21204

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of cartifier

Alan V. Abrams

27. Menner of Death
1 SNatural
2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending Investigation

6 ☐ Could not be determined



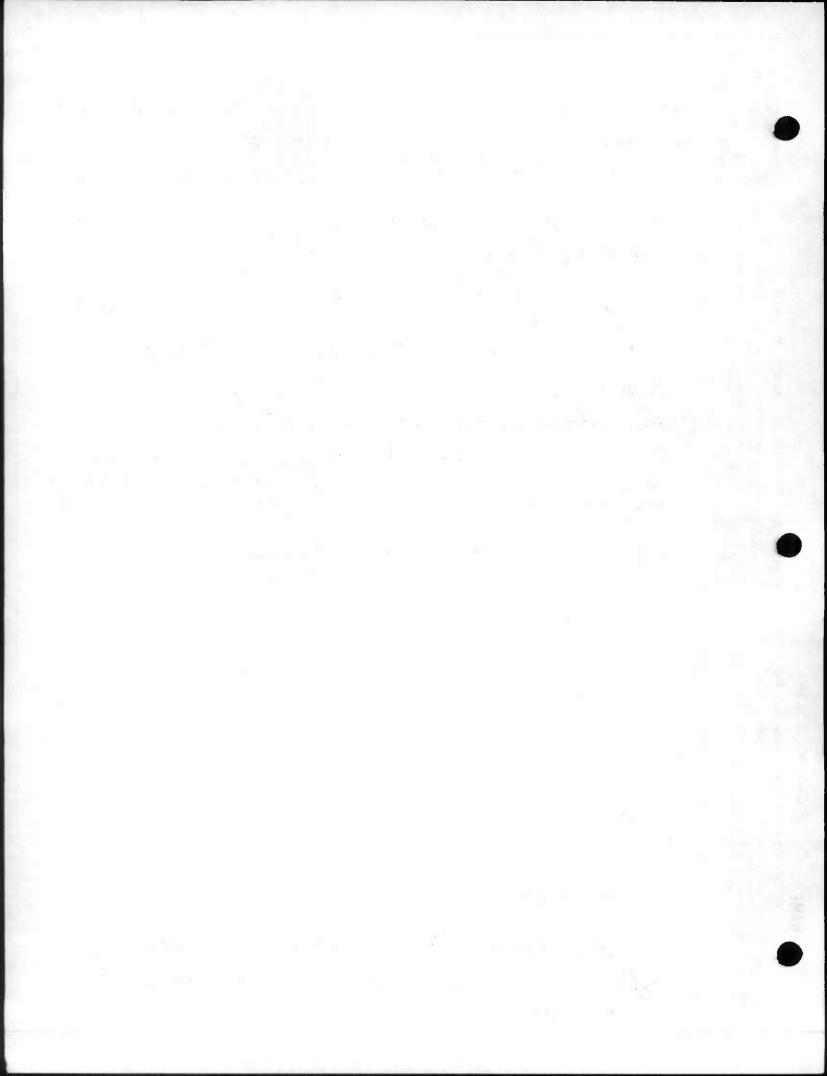
28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

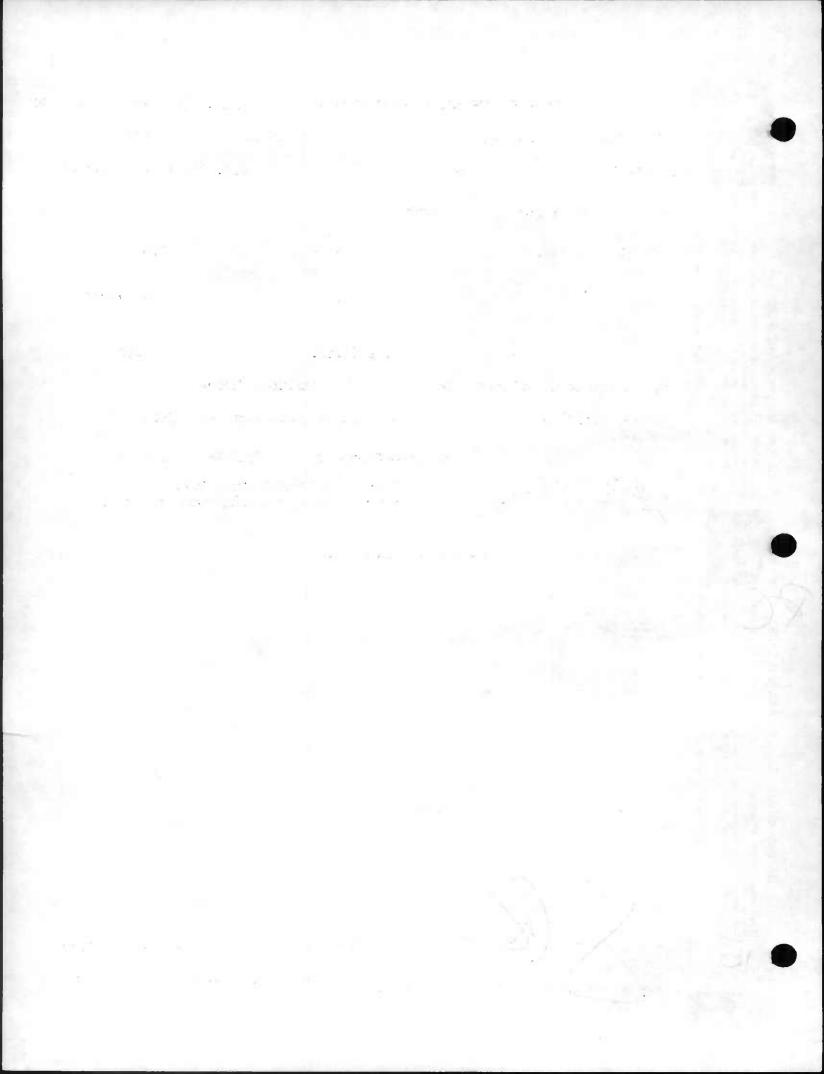
and the same of th Statement of a transfer of the

State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of Death	F	leg. No.	160	30
Dhusi	Jan	1. Decedent's Name (First, Middle, Last	7)			2. Date of Dea Month		yaar 3. T	ime of Death
Physic /Med		HELEN A. FORI				APRIL		1998 1	158
Exami		4a. Facility Nama (If not institution, give	street end number)		4b. City, Town, or	r Location of Death	4c. County	of Death	
		ST. AGNES HOSPITAL			BALTO.,		N	1/A	
Funeral Director		5. Social Security Number 6. Se 087-05-7867 Usual Residence of Decedent	7. Age (In yrs. la	5 Yrs. If Und Month:	ar 1 Year If Undar 24 Hr s Deys Hours Mir		Year /	9. Birthplece (S Country)	Stete or Foreig ROINA
land		10a. State 10b. County	10c. City,	Town or Location				10d. Ins	side City Limits
Mary Hah	ō	MA NA		BALTIM	ORE			10	IVes 2□No
128	Je C	10e. Street and Number			ip Code	1 ,	10g. Citizen of V	Whet Country?	
3a o	0	3414 ALTO	ROAD		21216		4.	5	
ter death with the Marylan Items 23s or 28s-f show Items 13st or 15st ed	Funeral Director	11. Marital Status	12. Was Decedent Evar in U,S	. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Maxican, Pua	Specify Yes or No-	14. Rac	e - American Ind	lian,
9 9	by	1 ☐ Navar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yas, Giva Year or Dates:		2 DNo Specify:	irto Hican, atc.)	Specify	ck, Whita, atc.	R
n 72 hours "natural", edical Ex	ted	15. Decedent's Edu		16a. Decedent's Us	ual Occupation	4.5	16b. Kind of Bu	usiness/Industry	
hin 7	Completed	(Specify only highest gred Elementery/Secondery (0-12)	College (1-4or 5+)	lifa. DO NOT		orking	0		
77 75 1 44	NO.	12	-0-	JEA	MTRESS		GARI	MENT	
be filed tal Hygi d other event, t	Be (17. Fathar's Nama (First, Middle, Lest)			18. Mother's Na	ame (First, Middle,	Meiden Sumem	ne)	
	2	NOAH FOR	20		ID)	A PAR	KS		
d 2 should th end Mer 7 is marke traumatic		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailing Addre	ss (Street and Number or F	7			
		CLARENCE HEND	ERSON SON)	3414 HC		ALTIMO	RE, MI	0 2121	6
ges 1 en it of Heal if Item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	COL	ace of Disposition (A metery, cremetory of	eme of other place)	Date	20c. Location -	City or Town, St	tate
a a a a		4 □ Donation 5 □ Other (Specify)		LID RING	E (EMETELI)	4-22-98	BALTO.	MD.	
emit. Pa epartman nportant: ny injury		21. Signatura of Funeral Servica Licans	600	22. Nama	and Addrass of Facility	4-22-98 EDD F	UNERS	AI SER	VICE
88E 88		Muilanero	Ko & A	1721-	27 N. Mr.	ROE St:			
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	lications that caused the death.	Do not enter the m				Appro	oximate
Physician		snock, or heart failure. List only of	ne cause on each line.						val Between It and Death
/Medical		Immediate Causa (Final	MYOC	MOINE	INFARCT	an			
Examiner		disease or condition resulting in deeth)	a	as a consequenca o					
	ě		546 (6)	as a consequence o	.,.			1	
deeth certificeta be axecuted e attending physician end ed for usa es the bunal-transit	Examiner	Sequentially list conditions	b. Due to (or	as a consequence o	();				
an er inal-t		Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Disease or Injury		20011.000.000	,				
rificeta be aw ng physician e es the bunal	Physician/Medical	Cause (Disease or Injury thet initiated events resulting in death) Last	C. Due to (or a	as a consequence of):				
ng pt	Med							1	
eeth cer attendin I for usa	and		d					1	
dee of fo	SICI	Part II. Other significant conditions con	ntributing to death but not result	ting in the underlying	cause given in Pert I.	23b. Did t	obacco use co	ntribute to the c	ause of death
by the a	hy					101	/es 2□ No	3 Probably	45 Unknow
es that igned be dat	by					-			
G 00 =						24a. Was o	en autopsy med?	24b. Were aut	topsy findings
e law requ hes been ge 2 shoul	Completed							completic of death?	on of causa
- 0	E					1 🗆 Y	es 2 Ao	1 ☐ Yas	2□ No
0 - 0		25. Was casa referred to medical			26. Place of D	eath (Check only or	ne)		
The ate h	0	examiner?	Hospitel: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3/3-	Other	Home 5 ☐ Resid		er (Specify)	
The ate h	m	1 Yes 2 No	Tan a control of	28b. Time of	28c. Injury at Work?	28d. Describe h			
Physician: The this certificate here director, page	To B	27. Manner of Death	28a. Date of Injury						
Physician: The this certificate here director, page	To B	1 Les (35-740	28a. Date of Injury (Month, Dey Year)	Injury M	1 Yes 2 No				
lending Physician: The eath. Cor. After this certificate hite funerel director, page	To B	27. Manner of Death 12 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			per or Rural Rout	e Number,
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ending Physician: The stath. or: After this certificate hither funerel director, page	Certification: To B	27. Manner of Death Natural 5 Pending investigation Accident 3 Suicide 4 Homlcide Death 29a. Certifier Certifying Physical Example	28e. Place of Injury - At hon building, etc. (Specify) stclan: To the best of my know ner: On the bests of examination	M ne, farm, street, factor ledge, death occurre on and/or investigation	1 ☐ Yes 2 ☐ No ny, offica d at the time, date end place, in my opinion, death occurrence.	City or Tow	ause(s) and madate and place,	anner es stated. and due to the co	ause(s)
the footbarot Attending Physician: The in 24 hours affer death. The Funeral Director After this certificate in place in the funeral director, page	edical Certification: To B	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigation determined	28e. Place of Injury - At hon building, etc. (Specify) stclan: To the best of my know ner: On the bests of examination	M ne, farm, street, factor ledge, death occurre on and/or investigation	1 ☐ Yes 2 ☐ No ny, offica d at the time, date end place, in my opinion, death occurrence.	City or Tow	ause(s) and madate and place,	anner es stated. and due to the co	ause(s)
To the loss list of attending Physician: The within 24 hours affer death. To the Funerial Director: After this certificate is completary tilled in by the funerel director, page	edical Certification: To B	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigation determined	28e. Place of Injury - At hon building, etc. (Specify) stclan: To the best of my knowner: On the bests of examination and manner stated.	M ne, farm, street, factor ledge, death occurre on and/or investigation	1 ☐ Yes 2 ☐ No ny, offica d at the time, date end place, in my opinion, death occurrence.	City or Tow	ause(s) and madate and place,	anner es stated. and due to the co	ause(s)
the footbarot Attending Physician: The in 24 hours affer death. The Funeral Director After this certificate in place in the funeral director, page	edical Certification: To B	27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homlcide 29a. Certifier (Check only one) 29b. Signature and title of certifier Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc Calc	28e. Place of Injury - At hon building, etc. (Specify) stclan: To the best of my knowner: On the bests of examination and manner stated.	M ne, farm, street, factor ledge, death occurre on and/or investigation	1 ☐ Yes 2 ☐ No ory, offica d at the time, date end place, in my opinion, death occ	City or Tow	ause(s) and madate and place,	anner es stated. and due to the co	ause(s)



sician	1. Decedent's Name (First, Mi	iddle, Last				THE STATE OF		2. Dete of De Month		Year	3. Time of Dea
edical				FREDER	ICK GR	IFFITH,	Jr.	April		998	11:09 A
miner	4e Fecility Neme (If not institu						4b. City, Town, or Baltim	Location of Deet		ty of Deeth	
-	Good Samari 5. Sociel Security Number	6. Se	_		s. last birthday)	If Under 1 Yea					place (State or Fo
ral tor	213-30-7715 Usuel Residence of Decedent	12	M 2□ F	64	Yrs.	Months Deys		Jan. 2	th W. Year 5, 1934	M1S	ssouri
	10a. Stete 10b. Cou	nty		10c.	City, Town or Lo	ocation					10d. fnside City Li
to	MD Ba	ltim	ore		Fork						1□ Yes 2€
lrec	10e. Street and Number					10f. Zip Code			10g. Citizen of	Whet Cou	intry?
alD	12703 Wilson	Ave	•			21	051		USA		
Be Completed by Funeral Director	11. Maritel Status 1 □ Never Married 2 ☒ N 3 □ Widowed 4 □ Divor		Armed F	2 No		Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 No	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	o- 14. Race - American Indien, Black, White, etc. Specify: White		
Completed	15. Dece (Specify only hig	dent's Edu	cation	n	16e. Dece	dent's Usuel Occu	pation during most of weed)	16b. Kind of Business/Industry			ndustry
mple	Elementary/Secondary (0-1			(1-4or 5+)							
S	17. Fether's Neme (First, Midd	do I not)	1		S	teamfitt	-	ame (First, Middle		ion	
Be	Thomas Frede		Criff	ith. S	r			d Zinkan	, warden Sume	nne)	
P _C	19e. Informent's Neme/Releti			Lui, S.		ng Address (Stree	et end Number or F		er, City or Tow	n, Stete. 7	ip Code)
	Joan P. Grif		p=,				n Ave.,		21051		
	20e. Method of Disposition			1	. Plece of Dispo	osition (Neme of metory or other pl	ece)	Date	20c. Location	- City or T	own, Stete
	1 N Burial 2 ☐ Cremetic 4 ☐ Donetion 5 ☐ Other			State Pa		Cemeter		4/22/98	Balti	more,	MD
					2:	2. Neme end Add	ess of Fecility				
once.	21. Signeture of Fuherel Service Licenses 22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214										
	23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, In										
n	1									1	Onset and Deet
al er	Immediate Ceuse (Finel disease or condition			Myocard	dial In		Min				
	resulting in death) Due to (or es e consequence of):										
Examiner			b								
xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or es e consequenca of):							i	
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Tig.	Ceuse (Disease or injury	< '		D 1-		Α					
edical	cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in deeth) Lest	1		Due to	(or es e consec	quence of):					
edical	that Initieted events	1	d	Due to	(or es e consec	quence of):					
edical	that Initieted events						iven in Pert 1.	23b. Dld	tobacco use,c	contribute	to the cause of de
edical	Ceuse (Disease or injury that initieted events resulting in deeth) Lest						iven in Pert 1.		tobacco use c		to the cause of de
Physician/Medical	Ceuse (Disease or injury that initieted events resulting in deeth) Lest						iven in Pert I.	10	Yes 2 No	3 □ Pro	obably 4□Unk
Physician/Medical	Ceuse (Disease or injury that initieted events resulting in deeth) Lest						iven in Pert I.	1 🗆	/	3 □ Pro	Obably 4 Unk
Physician/Medical	Ceuse (Disease or injury that initieted events resulting in deeth) Lest						iven in Pert 1.	1 🗆	Yes 2 No	3 □ Pro	obably 4 Unk
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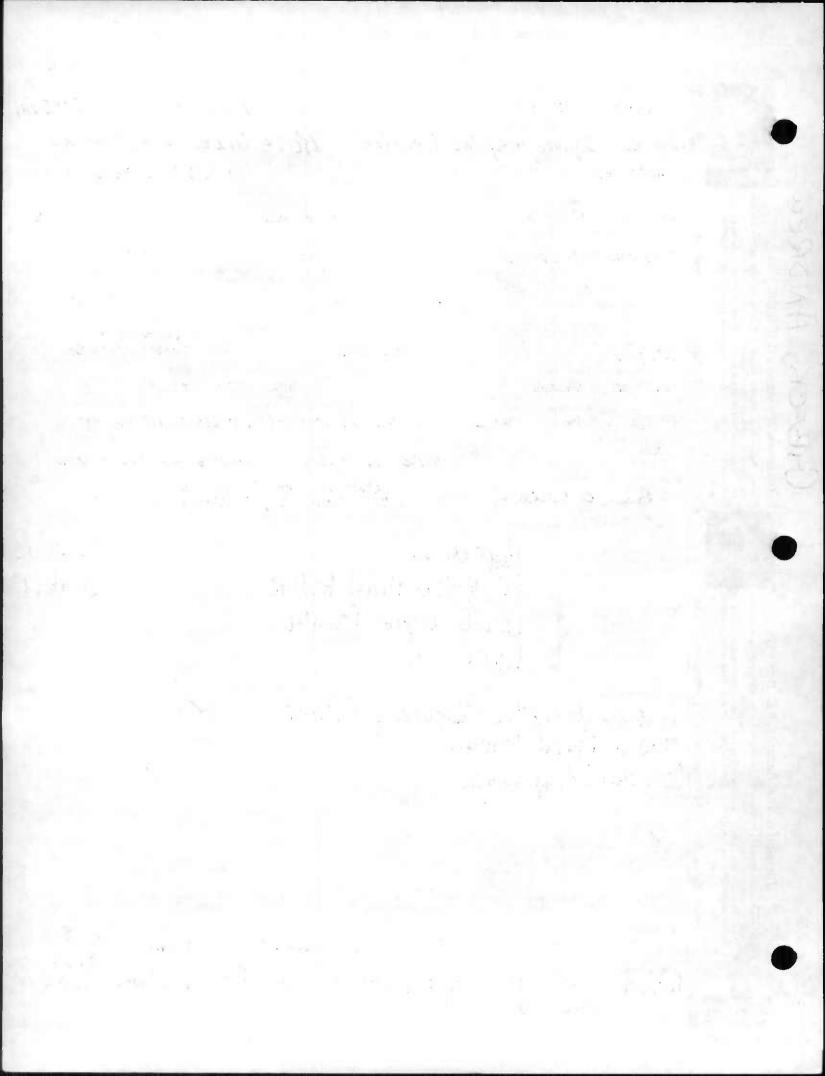
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:55 HM Andrew H. Gibeck -IPRIL 6, 1998 4c. County of Death /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Loca tion of Death Examiner Sept. 18, 1923 BALTIMORE en 1er DITAL HRANKLIN SQUARE HOS If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex. **Funeral** Min. Months Days Hours 186-16-5639 74 Pennsylvania Director Usuel Residence of Decedent FIBECK, ANDREW with the Meryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show Baltimore Maryland White Marsh 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be to 5713 Carrington Drive U.S.A. 21162 r death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☑XYas 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status Black, Whita, etc. hours after 1 Never Married 2 Married "natural", or 1 ☐ Yas 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) d 2 should be filed within 72 th end Mentel Hygiene. 7 is marked other than "nu Commercial Elementery/Secondary (0-12) College (1-4or 5+) Bricklayer Construction Co. 8th grade 18. Mother'a Name (First, Middla, Maiden Surname) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be William Gibeck Anna Marie Carey 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health e Evelyn T. Gibeck 5713 Carrington Drive, White Marsh, MD (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata Department of Important: If it injury or Gardens of Faith Cem. 4/18/98 Baltimore, Maryland 4 Donetion 5 Other (Specify) 22. Nama and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funarel Sarvice Licensae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Buin a Wellen 21236 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical **Examiner** Examiner law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Box 68760. physician Physician/Medical 88 use 23b. Did tobacco use contributs to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. o the 6 1 Yss 2 □ No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of ceuse of death? hes 2 1 No 1 Yes 2 No certificate 25. Was cese referred to medical examiner? Physician: Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 5 Pending investigation 1 WNetural or Attending 1 Yes 2 No death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital of Within 24 hours at To the Funeral D completely filled it 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated. edical 2 Medicat Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29d. Data signed (Month, Day Year) 295. Signature and little of certified 29c. License number Kesident

30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) ProSply Sanchez M.D. 9000 Frank

1 1998 32. Ragistra Jakier albrendon Gandalle

State Registrar

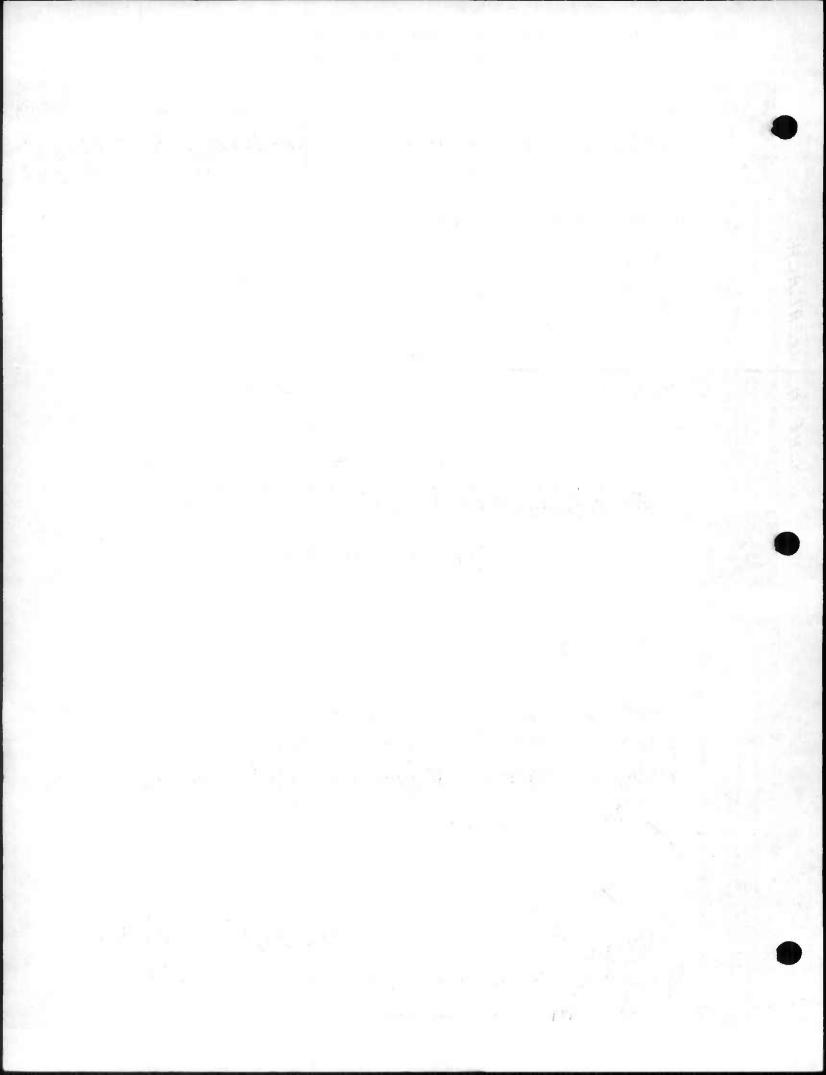


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Usual Residance of	Decedent								3071301		
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ABE 19a. Informant's Na	ma/Ralationship /T	ype, Print)	MARCI		Addrass (St		AURA er or Rure	l Routa Numbe	er, City or Town,	TTIK State, Zip Code)
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21. Signature of Fu	neral Service Licens	100				drass of Facil					
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	200									Onse	et and Death
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Part II. Other signifi	cant conditions co	ntributing to daath	but not resi	ulting In tha un	derlying caus	a givan In Part	l.	23b. Did	tobacco uae cor	ntribute to the	cause of death?
								1 🗆	Yes 2 No	3 Probably	4 Unknown
								24a Was	an autopsy	24b. Wara au	topsy findings
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								1 🗆	Yas 2006		
25. Was casa rafarr	ad to medical					ac Di-	o of Death	(Check only		1 Ll Yas	2 No
axaminar?	,	Hospital:	ient 2 🖺	ER/Outpatient	3□ DOA	Other			dence 6 □Oth	ar (Specify)	
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DHMH 16 Rev 6/95

				State	of Ma	-		tment of F ificate of	lealth and I <i>Death</i>		giene Reg. No.	98	2534
	Phonelet		1. Decedent's Name (First, Middle	Last)						2. Deta of Dee Month	oth	Voes	3. Time of Death
	Physici /Medic		Theresa Rita	Gerlad	ch					APRIL	Day 16	1998	10:40AM
	Examir		4a. Facility Neme (If not institution,						tb. City, Town, or t	ocation of Death		inty of Deeth	
			CITIZENS	NURSI				if Undar 1 Yaar	HAVRE d	E GRAC		ARFOI	RD
	Funeral Director		5. Social Sacurity Number 212-03-9256	6. Sax 1 □ M 2 💢 F	95	e (In yrs. last birt	Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day Oct. 10	1902	9. Birthpi Coun	ece (State or Foraign try) ore, Maryland
			Usuel Residence of Decedent] 00					000.10	, 1502	Datum	ore, har y zar ki
	srytan show dat	_	10a. Sfate 10b. County			10c. City, Town	or Loca	ition				10	Od. insida City Limits
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	death with the Maryland ms 23a or 28a-f show max be notified at	Funeral Director	10e. Streef and Number					10f. Zip Code				of Whef Coun	try?
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0	or iter		1 Nevar Married 2 Marrie	Armed F ed 1 ☐ Yes				ispanic Origin? (Si n, Mexican, Puert	Rican, efc.)	В	Bleck, White, e		
00	France, o	1 by	3 X Widowed 4 □ Divorced	If Yes, G Yeer or I	Detes:		1L	Yes 2 No	Specify:		Spe	whi	te
2	be filed within 72 hours after death with the Marylar and Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be political at	Completed	15. Decedent's (Specify only highest	Education grada completed	16a. Decedent's Usuel Occupetion (Give kind of work done during most of working					king	16b. Kind of	f Business/Ind	ustry
12	willy one than	dmc	Elementery/Secondery (0-12)	College	(1-4or 5	+) Coo		NOT use retired	1)		Freddi	010	
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	and n 27 er tr		Joan & Vincent	Ferracci				num Rid	~	Forest			
O.	7 9 5		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removel from	State	1		ion (Name of tory or other plac		Dete		on - City or To	
Baltimore,			4 ☐ Donation 5 ☐ Other (Sp. 21. Signeture of Funerel Şerviçe L	19-12-11-12-11		Sacred I		Of Jesus	Cemetery 4	/20/98	Baltim	ore,Ma	ryland
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Ü.			23a. Pert1. Enter the disaase, or coshock, or heart failure.	complications that	caused	the death. Do n	11	750 Bela the mode of dyln	g, such es cardiec	Kingsvi or respiretory en	lle,Marest,	aryland	d 21087 Approximete
	Physician		snock, or heart failure. List o		ir							į	Interval Between Onsef and Death
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o,	A Comment		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury			Due to (or as a c	onseque	ence of):			1		
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DIVISION	or Attending effer death. Director: Afte	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 288. Plac	a of Inju	ry - At home, fer . (Specify)	m, street	t, fectory, offica		28f. Location (S City or Tow		imber or Rura	Routa Number,
ב	ral Di	O	×										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	edlcai	29a. Certifier (Check only one) Check only 2 Medical E	Physician: To the xaminer: On the b end mar	pasis of	examinetion end	death o	ccurred et the tin stigetion, in my o	ne, dete end placa pinion, deeth occur	, and due to the o rred et the time, o	ause(s) and date end pled	menner es st ca, end due to	eted. the ceuse(s)
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	1		31. Date filed (Month, Day, Year)	311) Î	MNICH	W	us ti	v4. 11	1y · 1	10 10)	
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:4591 Carl Edward Graham, Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Gilchrist Center Towson If Under 24 Hrs. Baltimore Co. 8. Date of Birth (Month, Day, Year) May 12, 1916 If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1₽M 2□ F Months Days Hours Min Yrs. Baltimore, Md. 213-10-3393 Usual Rasidence of Decedent 81 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. #2012 United States 8810 Walther Blvd. 21234-0019 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Worker Electronics 12 n/a 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) William James Graham Christine Kalbskopf 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Mary (nee Linder) Graham 8810 Walther Blvd. Apt. #2012 Balto., Md. 21234-0019 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 DaBuriai 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gard. 4/21/98 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Llouisee Jefffrey L. Gair 22. Name end Addrass of Facility Ruck Towson Funeral Home, Inc. air 1050 York Rd. Towson, Md. 21204 Part Envertee designs, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart the mode of dying, such es cardiac or respiratory arrest, Approximete interval Between Onset and Death Hodgians lymphonie immediate Cause (Final diseese or condition resulting In death) Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence

Physician /iviedical Examiner

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within 24 hours after deal To the Funeral Director:

8 Hospital

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Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

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Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiane.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at once.

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last

Part il. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I.

25. Was cese referred to medicei exeminer? 1 Yes 2 No 27. Menner of Death

5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 4 ☐ Homicide 29a. Certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28e. Dete of fnjury (Month, Day Year)

28e. Piace of injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. fnjury at Work? 1 Tes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to tha cause(s) and mannar stated.

29b. Signatura and

(Check only one)

29d. Date signed (Month, Day, Year)

30. Name and ad 31. Dete filed (Month, Day, Year)

State Registrar

32 Registrar's Signature grain Davidson

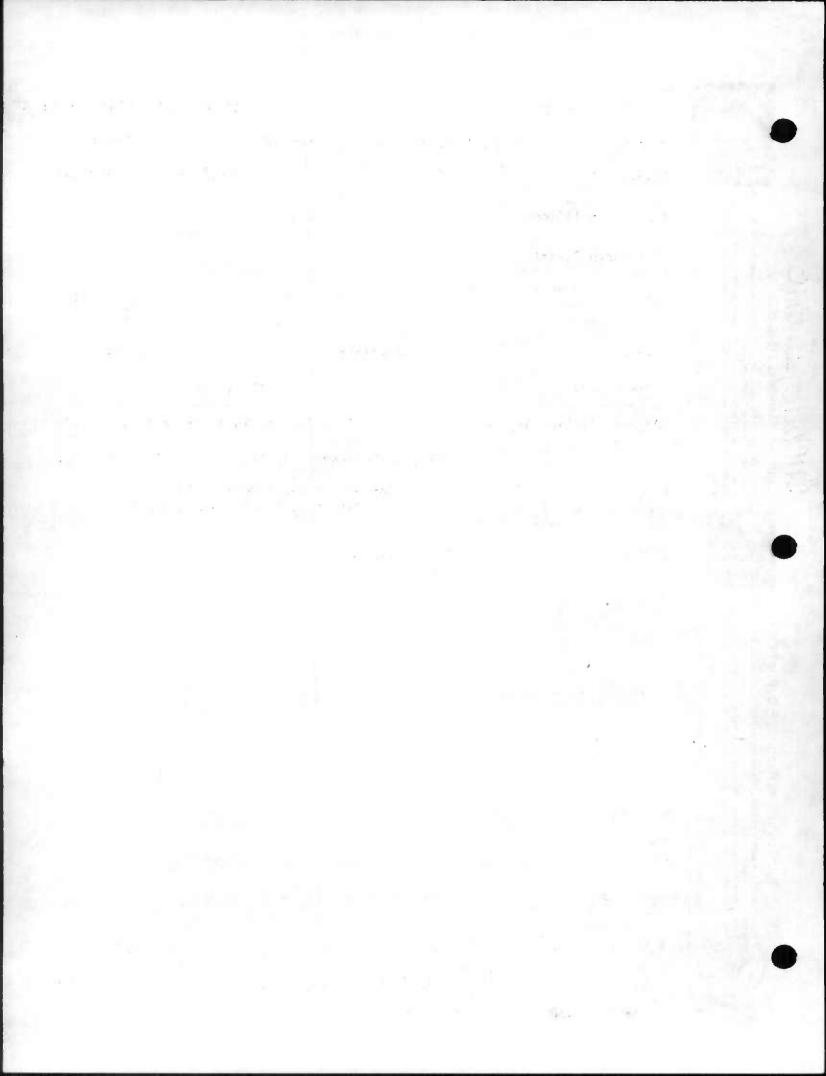
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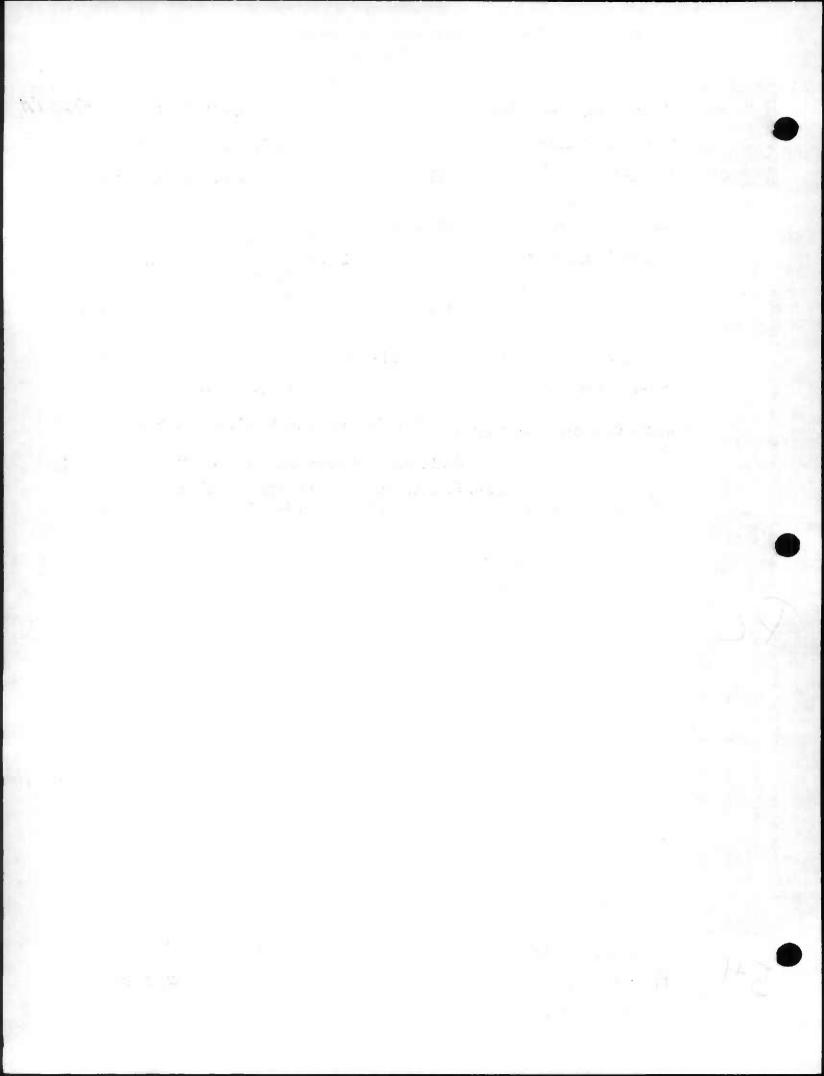
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Baltimore, Maryle Baltimore, Maryle permit. Pages 1 end 2 should Department of Haalth end Mar Important: if item 27 is marke any injury or other traumatic once.	21. Signatura of Funaral Sarvica Licans	1							
NEW YEAR	23a. Part1. Enter the disease, or compshock, or heart failure. List	ations that causad the	a death. Do not ent	ar the mode of dyir	ng, such as cardiac	or raspiratory arre	st, 2122	A	Approximate ntarvai Batween
Physician /Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death)	a	\wedge	nonia				1	Onset and Death Well
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.O. Box 6 the death certific y the attending p ached for use as	Part II. Other eignificant conditions co	entributing to death but n	ot rasulting in the u	ndarlving causa giv	van in Part I	23b. Did to	bacco use co	ntribute to ti	he cause of death?
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Division of Vital Re To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page		vsicien: To the best of milner: On the basis of axi	amination and/or in	occurred at the tir astigation, in my o	me, date and place pinl <i>on</i> , death occu	, and dua to the ca rred at tha tima, da	use(s) and mate and place,	annar as stat and due to th	ed. he cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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the 288	Director	Md. N/A		Baltin		ip Code		_	10g. Citizen of	Whet Coun	trv?
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** HENNING 7.10 AM HAZEL APRIL 98 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2 F Days Hours 83 Yrs. 155-05-7721 102/14 TEXAS Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No NIA Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2650 Dulany St. 21223 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify þ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondery (0-12) 8 PARAME 17. Father's Name (First, Middle, Last) College (1-4or 5+) Un Known File Clerk 18. Mother's Neme (First, Middle, Maiden Sumame) Be TUISOR Brooks Ellen FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Pleca of Disposition (Name of cametery, cremetory or other place) NANCY WATSON / DAughter 20a. Method of Disposition 2 BAIT Md. 21223 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Loudan Park Cemetery 22. Name and Address of Facility April 24, 1998 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Faneral Service Ligansee Kevin A. PAINER FUNERAL Home 35/2 Frederick Avenue 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tarker Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) FAILURE CONGESTIVE MEART ZRS Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown AIRWAY DISEASE CHKONIC OBSTRUCTIVE þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetlent 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide

HENNING, MAZE

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified as

2 should be filed within 72 hours after deeth and Mental Hygiena.

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m

Physician

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Examiner

Baltimore, Maryland 21215-0020

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efter death. Director: Aft 24 hours e To the Hosp within 24 ho To the Fune completaly fi

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Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number D44701 29d. Date signed (Month, Dey, Year) April 19,98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAIRACH CATON AVE BALTIMORE 900

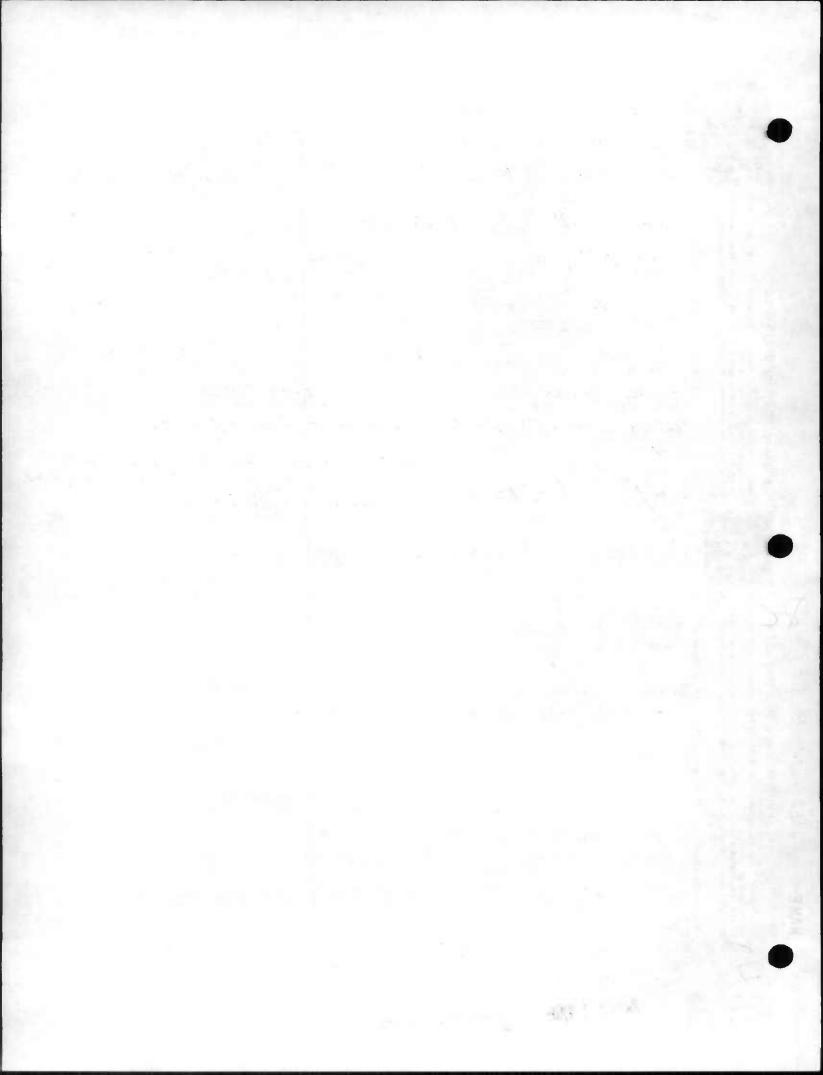
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31. Date file (17) The Day, Year)

32. Registrar's Signature Solia Varidson

29a. Certifier

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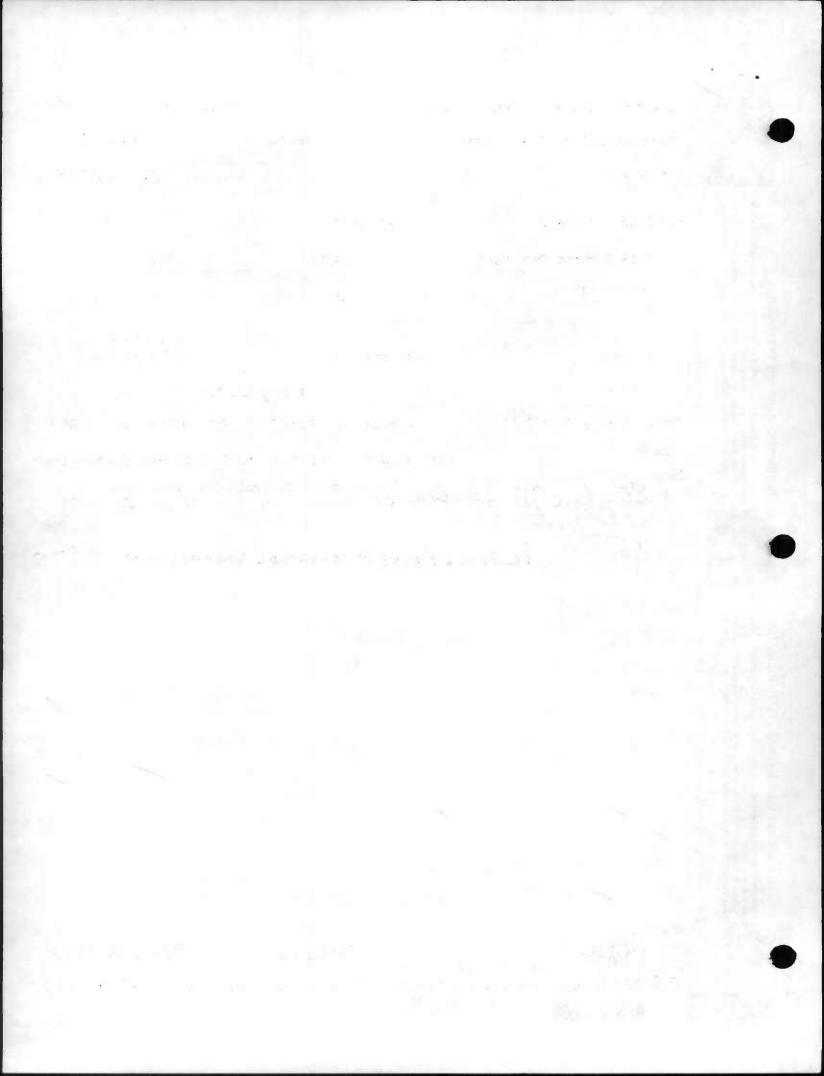
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nő. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1998 1920 April Donald Joseph Hueg Sr. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Feclity Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Days Hours Yrs. Director 216-30-8459 63 Maryland Nov. 29, 1934 Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2219 Harvest Farm Road Funeral 21784 death 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fler any injury or other traumatic event. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) American Glass Elementary/Secondery (0-12) College (1-4or 5+) 9 years Self Employed and Trim Co 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harry Heug Helen Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shirley Hueg (wife) 2219 Harvest Farm Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 4/22 Sykesville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licansee Loring Byers Funeral Directors, Inc. bong 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory errest, shock, or heart failure. List only one cause on each line. 8728 Liberty Road Randallstown, MD 21133 Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · PROBABLE ACUTE MYOLARDIAL INFARCTION ~ 5 min **Examiner** Due to (or as a consequence of) Examiner physician end the buriel-transit certificate be executed Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Se esn ò signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No p 24b. Were autopsy findings available prior to 24e. Wes an eutopsy Completed completion of cause of deeth? page 2 hes 1 Yes 2 No 1 Yes 2 No this certificate director, 25. Was case referred to medical examiner? 86 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA uneral 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. or Attend efter death Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of with p 24 hours e) To the Funeral D 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 140390 APRIL 19 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO. 5310010 COURT RO. #305, RANDALLIONIN MOZIC33

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SIOPM **Physician** HAMMSON (TEONG E 1798 APPLIE 18. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner RANDALLS TOUN BALTIMONE HSp1m DORTHWEST ENTER 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Deys Hours Yrs. 216-09-1498 Mar 21, 1920 Director Maryland Usual Residence of Decedent the Maryland r 28a-f show 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 21 No Directo Baltimore Rockdale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 enest of Health and Mertal Hygiene.
Ant: If item 27 is marked other than "natural", or items 23a or :
Any or other traumatic event, I'm Medical Example man U.S.A. 21244 3523 Meadowdale Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Biack, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: g White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) C & P Telephone Co. 12 Engineer 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Minnie Engel Harrison Harry B. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3523 Meadowdale Drive Baltimore, MD 21244 Mrs. Loretta Harrison 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) 4/21 Baltimore City, MD Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. notions 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or mart failure. List only one cause on each line. 21133 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ACUKE MYOCARDIAL Han Examiner YEARS Examiner CORON AM physician and the burial-transit The lew requires that the death certificeta be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) on of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): as 950 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. ed by the e 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown AMHY HAMIAS à 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed certificate has b lirector, page 2 s 1 Yes 2 No 1 Yes 2 No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 BOOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? bu 5 Pending investigation 1 Maturai 1 Yes 2 No 2 Accident -Divisi 6 Could not be determined 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of smillion 29c. License number APML 18.1998

State Registrar

31. Date filed (Month, Day, Yeer)

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32. Registrer's Signeture

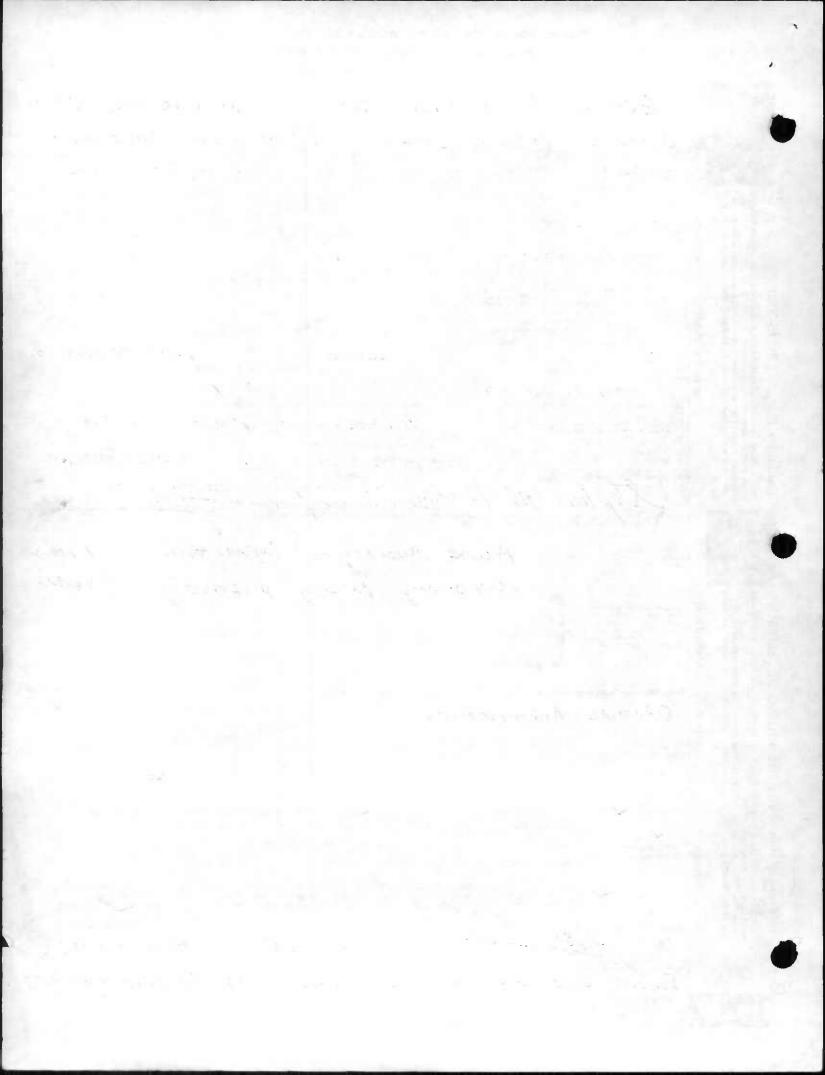
COUNT POAD RANDMUSTONN MD 21133

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

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						Ce	ertificate of	Death		Reg. No. 9	12	541
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Funeral		5. Social Security I	521	Sex 1□M 20XF	7. Age (In yrs. la 79	st birthday Yrs.	Months Days		8. Date of B	e, 1919	9. Birthpled	pe (State or Foreign
and		Usuel Residence of 10e. Stete	10b. County	-	10c. City,	Town or L	ocation				10d	Inside City Limits
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permit. Pages Department of Important: If it any Injury or o		21. Signature of Fi	uneral Service Lice	O. O.	AL		2. Name end Addre Eckhar		1 Chape	-1		21117
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Yaa **Physician** 8:42 AM OWEN **HOFFMAN** APRIL 1998 /Medical 4a Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 11 POMONA SOUTH, APT. ONE BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Year 6 Sex 7. Aga (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) **Funeral** 1₩ 2□ F Months Deys 81 Director DEC. 16, 1916 MARYLAND 216-07-8431 Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location r 28a-f ahow MARYLAND BALTIMORE BALTIMORE 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours after death with to not of Health and Mental Hygiene. Of: If Item 27 is marked other than "natural", or Items 23s or 2 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 11 POMONA SOUTH, APT. ONE 21208 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Marital Status Bieck, White, etc. 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) College (1-4or 5+) Elementary/Secondary (0-12) PRINTER PRINTING 18. Mother's Name (First, Middle, Meiden Sumama) 17. Fether's Name (First, Middla, Last) Be FRIEDA KATZENELL HOFFMAN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELEANOR HOFFMAN (WIFE) 11 POMONA SOUTH, APT. 1 BALTO., MD 2120 20c. Location - City or Town, State other t 21208 20b. Pleca of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition Date permit. Pages Depertment of Important: If It any Injury or o Buriel 2 Cramation 3 Removel from State BETH TFILOH 4/19/98 BALTIMORE, MD 4 Dogfation uneral Service L 22 SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 Approximate fntervel Between Onsat and Death this that caused tha daeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, rause on each line. **Physician** /Medical Immediate Causa (Finai 401 rua disaasa or condition resulting in deeth) Examiner Due to (or es a consequenca of): Examiner The law requires that the death certificate be executed physicien and the burial-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting In death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 80 signed by the a 23b. Did tobacco use contribute to the cause of death? Part ff. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 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Medical To the Fune (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner steted. within 2 physician 29c. License number Herdus 29d. Date signed (Month, Dev. Year) 29b. Signerum and title of certifier 30. N nd eddress of person who completed cause of deeth (Item 23a) (Type, Print) Pikesulle. Md. 21208

State Registrar

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31. Date filed (Month, Day, Yeer)

02, W. 22 Registrar's Signature

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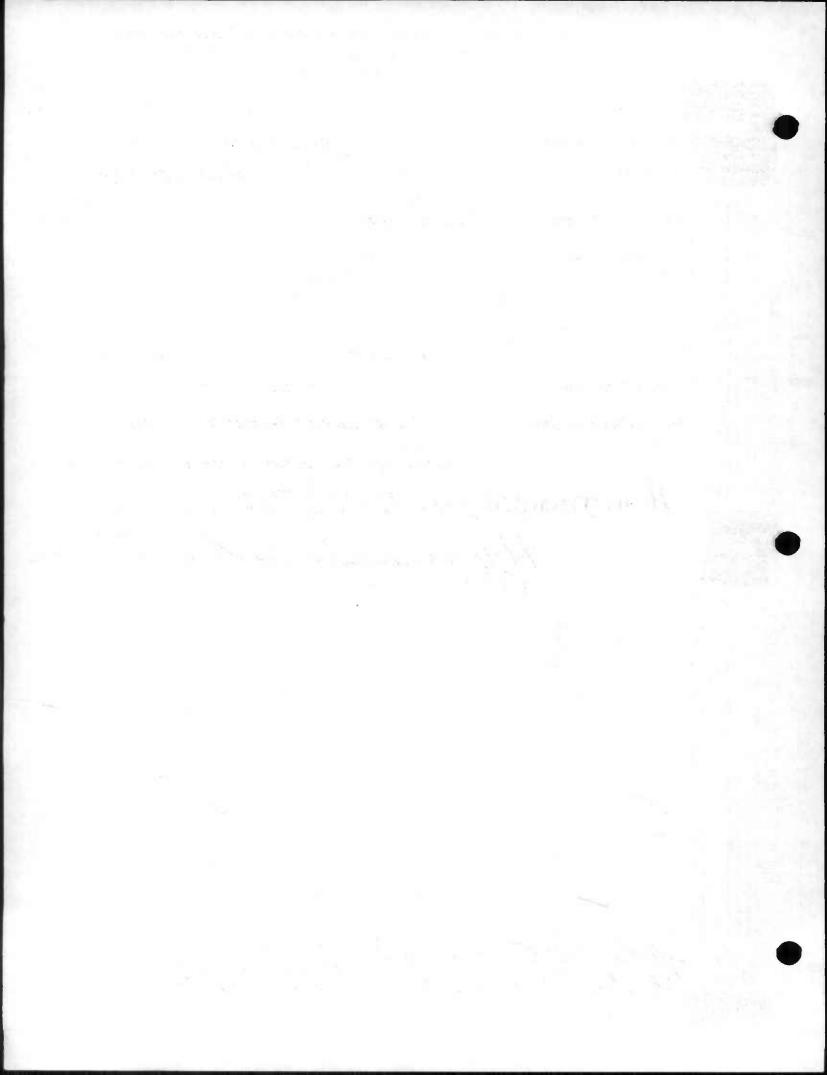
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Division of Vital Records, P.O. Box 68	that the death certifice ed by the ettending ph deteched for use as th	Physician/Med			d											
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State of Maryland / Department of Health and Mental Hygiene

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Exa	mine	r	4a. Fecility Nema (If not institution,	1.4	" 559.T	-		0 -		,	Or Death				
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2058	a		21. Signature of Funaral Sarvica Licansea 22. Nama and Address of Facility HARTLEY MILLER FUNERAL HOME 7527 HARFOLD RD BALTO, MD 21334												
	п		23a. Part1. Enter the disease, or co shock, or haart failura. List or	mplicetions that cause ly one causa on aach	ed the deat lina.	th. Do not antar	tha moda of dy	ying, such as cerdi	ac or raspiratory a	rrest,	1	Approximate Intarval Between			
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ath cert	1	2		d	-										
es that the death certigned by the attending be detached for use			Part II. Other significant conditions	contributing to death	but not ras	ulting In the und	larivino causa o	riven in Part I	23b. Did	tohacco usa co	ntribute to t	the cause of death?			
at the d		J A						, vor mr are n				ably 4 M Unknown			
s tha	1	by a	Sick S	inus s	Luc	rome			-						
The law requires that the death certate has been signed by the attendire page 2 should be detached for use				inus s	100	1'50	- 64		24a. Was	an autopsy		a autopsy findings labla prior to			
ne law requires ti s hes been signe tge 2 should be o	1	Completed	Corona	ry ar	101 9	0,70	170		- pont	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	com	pletion of cause aath?			
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Physician: T this certificat ral director, p	3	0	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	ient 2	ER/Outpatiant	3 DOA	ther: 4 Nursing	Homa 5 ☐ Rasi	dance 6 Oth	nar (Specify)				
ng Pt ter th			27. Manner of Daath 1≱Naturel 5 ☐ Panding	28e. Data of In (Month, D	ury a <i>y Year)</i>	28b. Time of Injury	28c. Inj W	ury at ork?	28d. Dascribe	how injury occur	red				
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l or Attanding efter death. Director: After 3 in by the fune	1914	Certification:	3 Sulcida 6 Could no datarmine	ed 28a. Placa of II	njury - At h	ome, farm, straa 'y)	at, factory, office	A	28f. Location (City or To	Straat and Numb wn, Stata)	oer or Rural	Route Number,			
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To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this centific completely filled in by the funeral director,	00	edical	29a. Cartifiar (Check only one) 1 ← CertifyIng 2 ← Madicel Ex	Physician: To the besi aminer: On the basis	of axamina	wledga, death o tion and/or Inva	occurred at the stigation, in my	time, dete end ple opinion, daath oc	ce, end dua to tha curred et tha tima,	cause(s) and mo data and place,	enner es ste and dua to t	ted. tha cause(s)			
the the	100	_	29b. Signatura and titia of certifier	end mannar s	tated.		20c Llean	nsa numbar		29d. Data signa	d (Month D	av Voarl			
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10	10		30. Name and addrass of parson wh	•		n 23a) (Typa, Pr	rint)	ITAN HO	LD YA	I lock .	(Daren	Blud			
	24-4		JIHAD ALHARI 31. Data filed (Month, Day, Year)		_	S GO		THE ME) > [. 700	i well	DIVER	750 0 0			
Regi	State		31. Data filed (Month, Day, Yaar) APR 21	1998	who Do	Mura Widson Pa	ndell								

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 3 Time of Deeth 2 Date of Death Month Itaensler 1998 -a Herine Ni 4b. City, Town, or Location of Daeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deet Church Hospital Baltimore n/a Hours Min. Sept. 9, 1914 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 1 □ M 2 CXF Months Deys WestVirginia 215-22-4526 Yrs. 83 Usue! Residence of Decedent 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits Md. 1 ☐ Yes 2 No Baltimore Essex 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Plateau Road 21221 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Rican, etc.) 11. Merital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Salesperson Clothing 12th 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surname) Thomas Scott Ida Knox 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Cowan Jr./friend 5 Plateau Road Baltimore Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 4/20/98 Baltimore Md. 21. Signeture of Funeral Service Licensae 22. Name end Address of Fecility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the death. Denot anter the mode of dying, Such as cardiac or respiratory arrest, Md. 21221 shock, or haart failure. List only one cause on each line. Approximete Intervel Between Onsel end Death Immediete Ceuse (Final disease or condition rasulting in death) neumonia Due to (or es e consaquance of): Thotametive Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or Injury that initiated events resulting in deeth) Lest Due to (or es e consequance of): Due to (or es e consequence of):

Physician /Medical Examiner

important: If item 27 any injury or other tr

Physician

/Medical

Examiner

Director

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Be Completed by

Funeral

Director

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Maryland 21215-0020

ore,

Physician/Medical Examiner Be Medicai Certification:

physician and s the buriel-trensit Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Qivision of Vital this illed in by the f epital or Al

	d				
Pert II. Other eignificent conditions cor	ntributing to death but not re-	sulting In the underlying ce	use given in Part f.		se contribute to the ceuse of death?
				24a. Wes en eutops performed?	evailabla prior to completion of cause of deeth?
25. Was cese referred to medical			26. Piece of Dr	eath (Chack only one)	
exeminer?	lospital:	☐ ER/Outpatient 3☐ DO/	Other		□Othar (Specify)
27. Manner of Deeth 1. Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	c. Injury at Work? 1 Yas 2 No	28d. Describe how injury	occurred
3 Suicide 6 Could not be datarmined	28e. Place of Injury - At h building, atc. (Speci	nome, ferm, street, factory,	office	28f. Location (Street end City or Town, State)	Number or Rural Route Number,
29e. Cartifiar (Check only one)	sician: To the best of my kniner: On the basis of examine end menner stated.	owledga, deeth occurred a etion end/or invastigation,	t the time, date end place In my opinion, daeth occ	ea, and dua to tha causa(s) a curred at the time, dete end p	nd mannar as statad. lece, and dua to tha causa(s)
29b. Signature and title of certifier		29c.	License number	29d. Date	signed (Month, Dey, Year)

April 17, 1994

well Hospital.

State Registrar

31. Dete filed

Registrar's Signeture Randell

and addrass of person who complated cause of deeth (Itam 23a) (Type, Print)

Physician /Medical Examiner burial-transit

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Division of Vital Records,

Attending Physician:

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Pages 1 and 2 should be filed within 72 hours aftar nant of Haaith and Mental Hyglena.
int: If item 27 is marked other than "natural", or ite

permit. Pagas 1 and 2 Department of Haaith a Important: If Item 27 Is

altimore, Maryland 21215-0020

5 Pending invastigation 1 Natural 2 Accident 6 Could not be 3 Suicide

4 Homicide 29a. Certifier

28a. Date of Injury (Month, Dey Year) found 3/27/98

found:residence

fourid 9:35 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2XX No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3706 Nortonia Rd. Baltimore, Md.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainle. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sign ture and title of certifie

Ne

APR 21

29c. License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

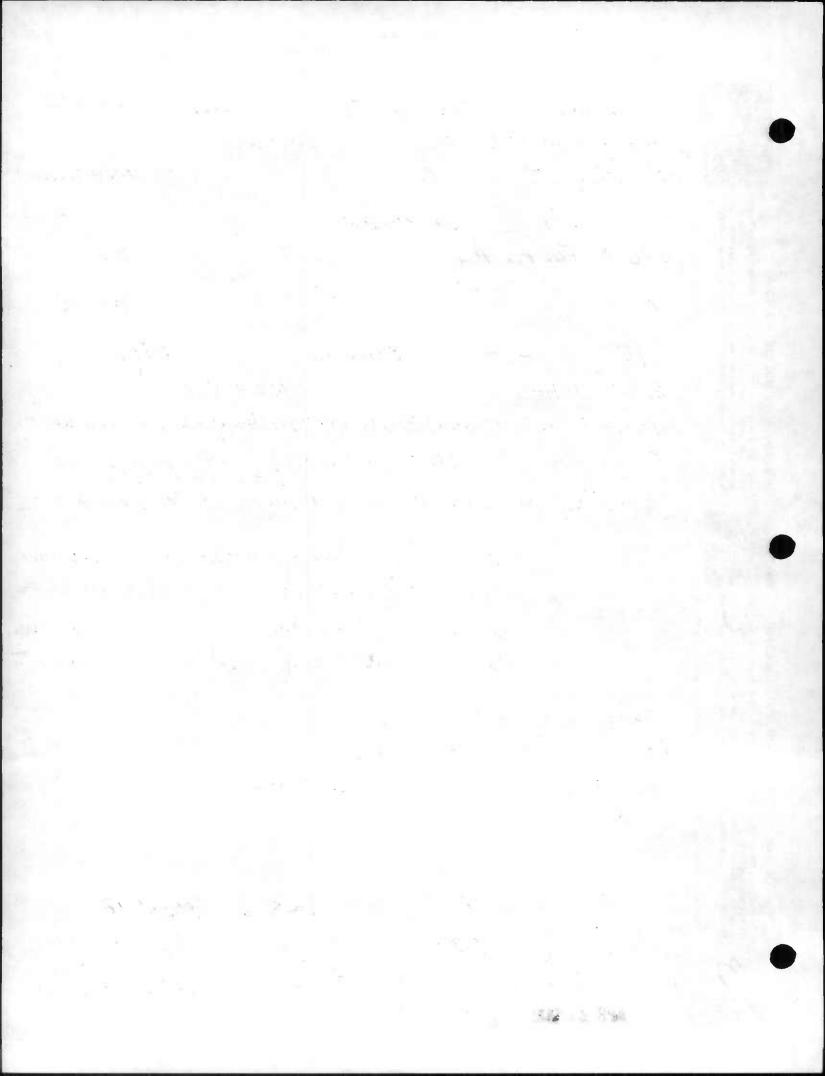
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State Registrar

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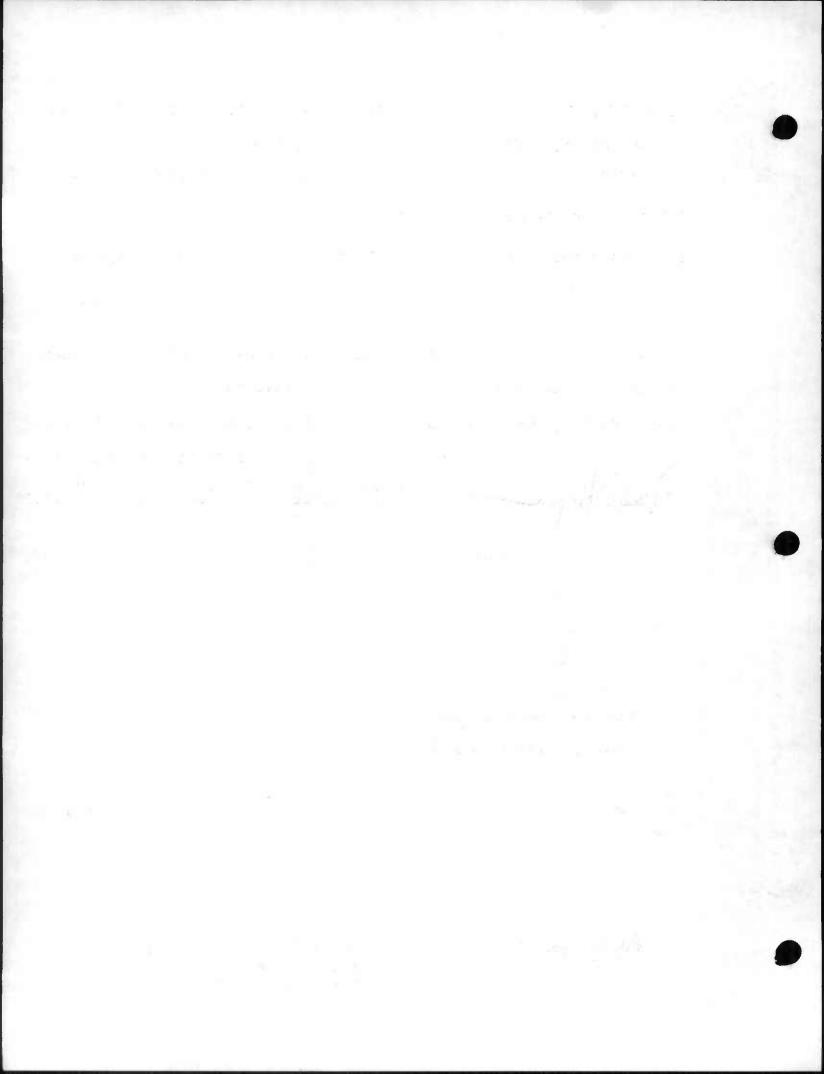
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				ertificate of Death	Reg. No	98 2	547
	5		1. Decedent's Neme (First, Middle, Last)	2.	Date of Deeth Month De		3. Time of Deeth
	Physicia /Medica		Willie Joe James	S/JVa	April	18 1998	6 33
	Examine	_	4a Fecility Neme (If not institution, give street and number)	4b. Clty, Town, or Locati		. County of Deeth	7170)
		٥,	5. Social Security Mumber 6. Sex 7. Age (In yrs. last birthd)	DACTIMOR If Under 1 Yeer If Under 24 Hrs. 8		N/H	lane (State or Engine
L	Funeral Director		5. Social Security Number 6. Sex 1	Months Devs Hours Min.	Dete of Birth (Month, Dey, Yeer, -/0-2	4 NORT	lace (State or Foreign try) H (ARVLINA
	show		10a. State 10b. County 10c. City, Town or	Location		1	Od. Inside City Limits
	the Mar 28a-f s	cto	MD N/A BALTI	MORE			1 🗇 🗸 🗀 No
	death with the Maryland me 23e or 28e-f show	Funeral Director	1626 N. Fuc row Ave	101. Zip Code 21217	10g. Ci	tizen of What Coun	try?
	items items per m	une		 Was Decedent of Hispenic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 	Yes or No- an, etc.)	14. Race - Americ Black, White,	
21215-0020	urs a	þ	1 Never Married 2 Married 1 Yes, Give Year or Dates:	1 ☐ Yes 2 DNo Specify:		Specify: B/A	cK
5-0	72 hours 'natural', orcel Ex	Completed	15. Decedent's Education 16e. De (Specify only highest grede completed) (G	cedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)	16b. k	(ind of Business/Ind	dustry
121	than a	du	Elementary/Secondary (0-12) College (1-4or 5+)	5. PO NOT use retired)		STEEL	/
	be filed vital Hygie d other in	ပိ	17. Fether's Neme (First, Middle, Last)	18. Mother's Name (Fi	irst, Mjddle, Maldel	n Sumame)	
an	Mental Mental arked o	o Be	Willie JAMES	FloRA	(ox		
Maryland	2 should be filed and Mental Hygi la marked other aumetic event,	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mi	ailing Address (Street end Number or Rurel Re		or Town, Stete, Zip	Code)
			JUANITA CLAYTON GISTER) 30	2 W. 139m51- NEW	NORK,	N.y. 10	030
Baltimore,	S to I		20e. Method of Disposition 1 □ Suriel 2 □ Cremetion 3 □ Removal from State 20b. Place of Discemetery, Commentery, Commentery, Commentery, Commentery, Commentery, Commenter, Co	sposition (Neme of cremetory oyother plece)	Dayle 206, L	ocation - City or To	wn, State
Ë	mant ant: I		4 Donation 5 Other (Specify) MT. Z	ION (EMETERY 4:	30 98 LAN	SDOUNE	MD.
Bal	permit. Pag Department Important: I eny Injury o		21. Signature of Funerel Service Licensee	22. Name end Address of Fecility E. L	PHILL	143, P.A	•
_	00500		Noveth & Nector CFSP	721-27 N. MONROE	51BA	(70, MD.	
			23a. Part1. Enter the disease or complications that caused the deeth. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or re	espiretory arrest,		Approximate Interval Between Onset end Death
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	Examiner		disease or condition resulting in death) a. / el as la		ans	na i	MKNOWN
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	nd md	Examiner	Sequentially list conditions, Due to (or es e con	CIO JI COV			VI NOOCH
90	1	Ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Cancer		U	in Kansun
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0	that the deed by the destached	hys	Pert II. Other eignificant conditions contributing to death but not resulting in the	s underlying cause given in Part I.	1/		bably 4 Unknown
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ecc	as be 2 sh	pie	Up 1 sicola walk	ess 1		co of	mpletion of cause deeth?
<u>=</u>	The la	Cou	Constinution - 1	e hydralion	1 ☐ Yes	1 DNO 1	Yes 2KNo
Vita	cartificata rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Deeth (C	check only one)		
of	Physic this o	9	1 ☐ Yes No Hospital: Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		5 Residence Describe how Injury		y)
Division of	ding h. Aftar funa	틸	Natural 5 Pending (Month, Dey Year) Injur		. Describe from my	ary occurred	
/isi	Atten r deat ctor: by the	lica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm.		Location (Street e	and Number or Rure	el Route Number,
Ö	s afta M Dire	ert	4 ☐ Homicide building, etc. (Specify)		City or Town, Ste	re)	
	lospit I hour uners aly fille	edicai Certification:	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or				
	To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: Aftar this cartific completely filled in by the funeral director,	Medi	one) and manner stated.				
	5 1 V S		296. Signature and title of certifier	29c. License number	290.0	ate signed (Month,	1492
	0	1	· WYIN	133585	To f	711 10	10
_)		30. Name and address of person who completed cause of deeth (Item 23e) (Ty	(260g 45	esty Ho	Buss	1980
	Stat		31. Date filed (Month, Dey, Year) 32. Raggistrar's Frignature	Juda 00	e /M	2	1228
	Registra	100	31. Date filed (Month, Dey, Year) ARR 21 203 32. Registrar's Finature	hillian			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				,	Cert	ificate of	Death		Reg. No. 98	12548
	Physici /Medic	ai	1. Decedent's Name (First, Middle, Last) 4e. Fecility Neme (If not institution, give st	reet end number)	Kr	ASSA	KAT'S	2. Data of Dec Month	Dey	Yeer 998 1 45
	Examir uneral Director	ier	Joseph Richey F 5. Social Security Number 6. Sax 364-09-9089	Section 10 may		If Under 1 Yeer Months Days	Baltimo	ore 8. Dete of Birt (Month, De	N/A	9. Birthplace (Stete or Foreign Country) Maryland
Maryland	r 28a-f show inotified at	or	Usual Residence of Decedant 10a. State 10b. County Maryland Baltim		y, Town or Loca					10d. Inside City Limits 1 ☐ Yes 2 No
th with the P	23a or 28a- unt be notifi	al Director	10e. Street end Number 5513 Ashbourne F	Road		10f. Zip Code 21227			10g. Citizen of W	/het Country?
5-0020 72 hours after death with the Maryland	or items	by Funeral	11. Meritel Status 1 Nevar Married 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates:		es Decedent of Yes, specify Cut	Hispenic Origin? (S ben, Mexicen, Puer Specify:		14. Rece Black	- Americen Indien, k, White, etc. - White
29	rygiena. ther than "natural", ent, the Medical Ex	Completed	15. Decedent's Educe (Specify only highest grede Elamantary/Secondary (0-12)	ation completed) Collaga (1-4or 5+)			pation a during most of wo ad) or/Wind		16b. Kind of Bus	siness/industry
yland buld be file	P 0	To Be C	17. Fether's Neme (First, Middle, Last) Herman C. Kassak				18. Mother's Net Mollie	me (First, Middle, e Reill	Meidan Sumama	a)
more,	om 27 is		19a. Informent's Neme/Reletionship (Type Joan McGeehan, Co 20a. Mathod of Disposition 1	laughter 20b. F	304 Wh	nite Pi	ace)	Dete Dete	rna Par 20c. Location - 0	Steta, Zip Code) rk, MD 21146 City or Town, State more, Marylan
Balti permit.	Important: If It any Injury or o		21. Singular of Timeral Service Licensee		Amk 132	28 Sul	Funeral phur Spi	ring Ro	ad Ma	Arbutus aryland 21227
/N	ysician ledical aminer	er.	23a. Perti. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Carring		the lun.		c or respiretory er	rrest,	Approximate Intervel Between Onset end Death 2 + months
ords, P.O. Box 68760, requires that the death certificate be executed	nding physician and use as the buriel-transit	n/Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		or es e conseque					
, P.O. B	been signed by the attendir should be detached for use	by Physician/	Pert II. Other elgnificant conditions contr				iven in Pert I.			atributa to the cause of death? 3 ☑ Probably 4 ☐ Unknown
a e	0 0	Completed b	Chaoric of Chronic a	total fibri	Nation				en eutopsy rmed?	24b. Wara autopsy findings eveileble prior to completion of cause of death?
of Vital R	certificata rector, pa	Be	25. Was cese raferred to medical exeminer?	spital:		_ 0		ath (Check only o		1 Yes 2 No
DIVISION OF	After thi	Certification: To	27. Mennar of Death 1 ☑ Naturel 5 ☐ Panding 2 ☐ Accidant investigation	28e. Date of Injury (Month, Dey Yeer)	ER/Outpatient 28b. Time of Injury	28c. Inju	4 🗆 Nursing r		tence 6 40the	er (Specify) Hospizzi
3 Y	al Direction by	i Certific	3 Suicide 6 Could not be datermined	28e. Plece of injury - At he building, atc. (Spacify lien: To tha bast of my kno	y)			City or Tox	vn, Stete)	er or Rural Route Number,
To the Hos	To the Fund completely fil	Medicai	(Check only one) 2 Medical Examine 29b. Signature and title of certifier	r: On the basis of examine and manner stated.	tion and/or inva	stigetlon, in my	opinion, daeth occu	urred et tha time,	dete end plece, a 29d. Dete signed	and due to the ceuse(s)
			30. Name and addrass of person who com		n 23a) (Type, Pr	rint) Relf	U75 E B. FIN Willards R	N, MD.	4-19-	48 21137
	Sta	te	31. Date filed (Month Day, Year)	32. Registrar's Signe	iture		FILENDS IN	VIA , INEME		



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Stanley C. Kupnicki APRIL 19,1998 11:35 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth Oct 23 1909 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplaca (Stata or Foraign 6 Sex **Funeral** Months Min. 1₽M 2□F Days Hours Phila PA 88 215-09-6813 Director Usual Residence of Decedent the Maryland 10d. Insida City Limits 10a State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mental Hygiene. Important: If item 27 is marked other then "naturel", or itema 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be indiffed at MD Baltimore City Baltimore 1 XYes 2 No Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21231 309 S. Washington St. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 2 No Specify: by 35 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 th College (1-4or 5+) Baker-Whitely Waterman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Mastella Michael Kupnicki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorraine A. Ciepiela (daughter) 6015 Hanover Rd, Hanover, MD 21076 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 □ Cramation 3 □ Ramoval from State Oaklawn Cemetery Apr 22 Dundalk, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charlton Funeral Home 21. Signature of Funeral Service Licensee
Dean P Charlton 2007 Eastern Ave, Baltimore, MD 21231 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onsat and Death **Physician** /Medical Immediate Cause (Final CARDIOGENIC SHOCK/ SECONDARY TO 4 DAYS disaase or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner ACUTE INFARCTION sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): physician . ANDXIC ENCEPHALOPATHY 4 DAYS Physician/Medical the Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ed by SEVERE CORONARY ARTERY DISEASE ð 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 1 ☐ Yes 25 No 1 ☐ Yes 2 No certificate 25. Wes case referred to medical Be 26. Place of Death (Check only one) axaminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Medical Certification:

Box 68760, Division of Vital Records, P.O. i or Attending Physician: after death. Director: After this certific the Hospital or the Funding Di 5 ¥ 5 1 € 5

Kupnicki, Slanler

28c. Injury et Work? 5 Panding investigation 1 Naturel Injun 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) 29a, Certifier (Check only one) and manner statad.

D 41410

29b. Signature and title of cartifiar

29d. Date signed (Month, Dav. Year) 29c. License number

m.0 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER R. M. D. MEHTA 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Dete filed (Month, Dey, Year) State Registrar

APR 21 1998

32. Registrer's Signature Sina Davidson

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State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		CHARLES W	. KERBE	SR.						04/19		1 8,61	805 am	
	Exami		4a. Facility Nama (If n	ot institution, giv	a street and numbe	r)			4b. City, To	wn, or Lo	cation of Deat	h 4c. Count	y of Death		
			1103 McAD	OO AVENU	JE					YNN	OAK		BALTI	MORE	
	Funeral Director		5. Social Sacurity Num 215-07-070 Usual Rasidance of Di)5	3ax 7. / M 2□ F	78	t birthday) Yrs.	If Undar 1 Yea Months Day		Min.	8. Data of Bir (Month, Da 04/10/1	y, Year)	9. Birth Cour MARY	placa (Stata or Foreign ntry) LAND	
	yland mow		10a. Stata 1	0b. County		10c. City, T	Town or Lo	ocation						10d. Insida City Limits	
	Mar a-f et	ģ	MD	BALTIMO	RE		GWYN	N OAK						1 ☐ Yes 2% No	
	or 28	Sire	10e. Straat and Numb	er				10f. Zip Code				10g. Citizan of	What Coul	ntry?	
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21215-0020	within 72 hours after death with the Maryland iene. ' than "natural', or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Navar Married 3 Widowed 4		12. Was Dacedar Armed Force 1 1 Yas 2 1 If Yas, Giva Yaar or Dates	s?] No		Was Dacedant of If Yas, specity Cu 1 ☐ Yas 2 ঐ No		gin? (Spo , Puarto	ecify Yas or No Rican, atc.)		ice - Amarlo ack, Whita, ify: WHI	atc.	
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	nd 2		19e. Informent's Nam JOSEPHINE					ng Addrass (Street ACADOO A					n, Stata, Zij	Code)	
Baltimore,			20a. Mathod of Dispos 1 Burial 2 □ 0 4 □ Donetion 5	Cramation 3	Removal from Stat	a cem	atary, crar	esition (Nema of matory or other plants) MEMORIA		4	Data /22/98				
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	the daal the att	Physician/	Part II. Other significa	nt conditions o	ontributing to daath	but not rasultin	g in the u	ndarlying causa (given in Part I.		23b. Did	tobacco usa c	ontributa t	o the causa of death?	
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Division	or Attendition death	Certification:	2 Accident	invastigation Could not be datarminad	28e. Plece of I	njury - At homa atc. <i>(Spacify)</i>	ı, farm, str	M 1[Yas 2 1		28f. Location (City or To		ber or Run	al Routa Number,	
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\			30. Nama and address	a Th	complated causa of	daath (Item 23	a) Type.	Print) OMAC	Phys.	sici	aus P	· A., 4	Kol	ling cron	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month 3. Time of Deeth

Physician /Medic Examina

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Haalth end Mantel Hygiene. Important: If itam 27 is merkad other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified as 90x8.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

To the Hospital or Attanding Physician: The law requires thet the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attanding physician completely filled in by the funeral director, page 2 should be detached for use as the burial-Division of Vital Records, P.O. Box 68760,

MARGA	RET	Y				KENE	CALY	APRIL	18	1998	10) or PM
4e. Fecility Neme (If		give street end num	ber)					r Location of Deetl	4c. Co	ounty of Deeth	1	
Stella	Marie						Timon	ium, Md	Ra	ltimo	ro	
5. Social Security Nu		Sex 7	. Age (In yrs.	lest birthday)	If Unde	er 1 Year	If Under 24 Hr	s. 8 Date of Bir	th			State or Foreign
214-30-	-6388	1□M 2/4 F	8.3	Yrs.	Months	Deys	Hours Mir	Sep 30	y, Yeer)		intry)	Stete or Foreign
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												Yes 2 No
Md		imore		Towso	n , 1	Md.						1 103 5 10110
0e. Street end Num	ber				10f. Zi	p Code			10g. Citizer	n of Whet Cou	intry?	
24 Acon	n Circ	cle Ap	t. 10	1		2128	36		USA	A		
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3 Widowed	□ Divorced	If Yes, Give Year or Dat	es:	'	☐ Yes	2 180 NO	Specify:		Sp	pecify: Wh:	ite	
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ert II. Other stanific	ant conditions	contributing to dea	th but not resi	ulting In the un	derlying	cause ni	ven in Pert I	23b. Did	tobacco ue	e contribute	to the e	suse of death?
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								1 🗆 '	Yes 250	3 0 1	☐ Yes	2□ No
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exeminer?	lo	Hospitel:	patient 2	ER/Outpatient	3□ D	OA Ot	0.00	Home 5 ☐ Resid		Other (Spec	(h) LI	CDICE
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4 ☐ Homicide	determine	28e. Plece o building	f Injury - At ho j, etc. <i>(Specif</i>)	me, tarm, stre	et, factor	ry, offica		28f. Location (: City or To		um <i>per</i> or Hui	ai Houte	a Number,
9e. Certifier (Check only	Certifying I	Physician: To the bas	est of my know	vledge, deeth	occurred	et the ti	me, dete end pled	ce, end due to the	ceuse(s) an	d menner es	steted.	nuno(c)
one)		end manne	r stated.	ion end/or inv	estigation	i, in my	ориноп, авет осс	Juired et the time,	date end bis	rea, and due	to the C8	1uS0(S)
29b. Signature	of certifier	- 4	^		29	c. Licen	e number	4	29d. Date s	igned (Month	, Dey, Y	ear)
IV	a/tho	2				1	15564		7	20	TE	
,						/						

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

State

DR. EDDIE NAKHUDA

31. Date filed (Month, Day, Year)
APR 2 1 1998

d a longer to

FOR STATE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Kindle S.

Le Roy

Lemuel

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

•	_	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. N	0.							
	ļ	1. DECEDENT'S NAME (First, Middle, Last) Lemuel Lero	y Kindle Sr				2. DATE OF DEATH	DAY 100	3. TIME OF OEATH						
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (in yrs. lest birthday)	IF UNDER 1 YEAR		7, DATE OF BIRTH (Month, Day, Year)	71716	BIRTNPLACE (State or Foreign Country)						
P		170 01 0100	1 💢 M 2 □ F 5:	5 YRS.			(Month, Day, Year) Feb. 11,1								
2, 3 should	H.C	on. FACILITY NAME (If not institution, give street 14429 MCAGEE Hill			,	or Location of DE Scade	ATN								
1, 2,	5	RESIDENCE OF DECEDENT													
physician. burial-transit permit. Pages 1,	DIRECTOR	Md. (Va	shington	10c. CIT	v, town on Loc Cascad				10d. INSIDE CITY LIMITS? 1 YES 2 NO						
if permi	FUNERAL	100. STREET AND NUMBER 14429 MCASee Hill) Dd		1	101. ZIP CODE 21719									
trans	N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	VIIS ARMED	13 WAS D	ECENDENT OF HISPAN	IIC OBIGIN2 (Specify								
	BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, t	specify Cuben, Maxica ES 2 NO Specify	n, Puarto Rican, etc.)		Black, White, etc. Specify: White						
attend ise as	TED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDENT'S (Give kind of	USUAL OCCUPAT work done during is se retired.)	TION most of working	18b. KIND OF	BUSINESS/INDUS	TRY						
0 5	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		aborer		Gri	9c. COUNTY OF DEATH Washington 10d. INSIDE CITY LIMITS? 1							
by the hospital be detached for at once.	SOS	17. FATHER'S NAME (First, Middle, Lest) Charles L. Kindle					ME (First, Middle, Maid	len Surname)							
	BE	19a. INFORMANT'S NAME (Type/Print)		405 4444 1046	ABB8500 (0)		E. Ott								
5 5	2		emuer(Siste												
may be or. page		20a. METNOD OF DISPOSITION	206	PLACE AND DATE	OF DISPOSITION	Name of	DATE 20c.	LOCATION - CIT	or Town, Stata						
) w o o		Smiths burg Crematory Feb. 14, 1998 Smiths burg, Md.													
Page III dire		22. NAME AND ADDRESS OF FACILITY													
the fundable out.		Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783													
ethy tied fours afti enery tiled in by t emation, or remov nt, the medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. A/coho/ic Cardiomyopathy 2 years													
arts certificate he executed with mending physician and compilal hygiene prior to burial, or c, or other traumatic eve															
the distribution of the di		PART il. Other significant conditions	contributing to death b	out not reaulting	in the underly	ing cause given in									
s that ned by oth and	EDICAL	<u></u>							COMPLETION OF CAUSE						
r mguire been sig c. of Hea	Σ					1_		,-	1 TES 2 NO						
2 5年 年 上	N.	DID TOBACCO USE CONTR	IBUTE TO CAUSE C			UNCERTAI	NU								
1 年 1 日 日	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:	10			State, Zip Code) State, Zip Code, Zip						
Certificate The State , or Rem	PHYS	1 YES 2 NO 27. MANNER OF DEATH	2Sa. DATE OF INJURY	patient 3 🗆 DOA	4 Nursing H	NJURY AT	6 Other (Specify)	W IN ILIBA OCCIN	RED.						
tor this sufficed marked	>	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		JURY 1	WORK? YES 2 NO	200. 52001152110								
TENDI TOR A after to	TED B	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, stc. (Spe	f — At home, farm, cify)	street, factory, of	fica	261. LOCATION (Stre City or Town, St	I S. A. I Yes 2X NO 109. CITIZEN OF WHAT COUNTRY? U.S.A. IY Yes or No— 14. RACE — American Indian, Black, White, etc. Specify: White F BUSINESS/INDUSTRY It Mill aiden Surname) I Town, State, Zip Code) CLOCATION — City or Town, State Smithsburg, Md. 21783 Approximate Interval Between Onset and Daeth 2 YEAS SEASE Sylats Sylats Sylats Sylats I Yes 2 No NO NOMPLETION OF CAUSE DED DE DEATN? 1 YES 2 NO NOW INJURY OCCURED							
5 活想是	LET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	vledge, death occur	ed at the time, di	ste and place, and due	to the cause(a) and	manner as stated.							
THE HOSPITAL THE FUNETAL filed within 72	COMPL	onel	t: On the basis of examination	on and/or investigati	on, in my opinion	, death occured at the	time, date and placa	, end dua to the o	euse(s) end manner ea stated.						
THE HOSPI THE FUNE filed within	l w l	286. SIGNATURE AND TITLE OF CERTIFIER				294. LICENSE NU		29d. DATE S	IGNED (Month, Day, Year)						
는 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	9 0	Mill	h			D4547	12	► Feb.	rugry 12,1998						
		30. NAME AND ADDRESS OF PERSON WHO	Blud Cr	nithsby	Print)	aruland	21783	Divay	ne Shuhart MD						
		31. DATE FILE APR. 02 1 1998	32. REGISTIAN SHOW	LATURE Pand	00	714.0									

					State	of Marylai		rtment of F tificate of		d Mental H	/giene	3 1	2553
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	Physici /Medi		ROBERT	BROOK	E_KIRKWOO	D				April	Dey 7	Yeer 998	8:45 am
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		5			Rehab Cen	ter			Timoni		Balti	more	
	Funeral		5. Social Security Nun		6. Sex 1□M 2□F	7. Age (In yrs		If Under 1 Year Months Deys	If Under 24 Hours	Hrs. 8. Date of B	irth ley, Yeer)	9. Birthp Cour	place (State or Foreign
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	dand dand			0b. County		10c. C	ity, Town or Lo	etion				1	0d. Insida City Limits
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	r 28s	Director	10e. Street end Numb		TIIDIG		WBOII	10f. Zip Code			10g. Citizen of V	Vhet Cour	ntry?
	N with		1122 Cone	cordia	a Drive			21286			United S	+ >+ >	
	iter deati	Funeral	11. Meritel Status	00141	12. Wes Dec	adent Ever in U		Vas Decedent of H	lispanic Origin	? (Specify Yes or N	o- 14. Rec	e - Americ	an Indien,
0	ours efter death with the Manylan el, or tems 23a or 28a-f show Examiner must be notified at		1 Never Married	2 <mark>∑</mark> Marr	ried Armed F	2 ☐ No ive		Yes, specify Cuba ☐ Yes 2 No		uerto Hican, etc.)		k, White,	
00	ours iral;	d by	3 Widowed 4	Divorced	Yeer or I	Detes:			Specify:		Specify	whi	te
5	be filed within 72 hours efter death with the Maryland tall Hyglene. d other than "natural", or items 23a or 28s-f show avent, the Medical Examiner must be notified at	Completed	(Specify	5. Deceden only highes	t's Education st grede complated,		(Give	ent's Usuel Occup	during most of	working	16b. Kind of Bu	siness/In	dustry
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an	d be antal	o Be		uckey	Kirkwo	M							
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	1 and 2 s Health er lem 27 is	1	Mrs. Anna 1	Lee Ki	irkwood/w	ife		oncordia			Marylan		
re,	s 1 a f Hea ftem othe		20a. Method of Dispos	sition		20b.	Plece of Dispos	ition (Neme of etory or other plea		Date	20c. Locetion -	-	
altimore,	permit. Pages 1 and Depertment of Health Important: If Item 27 any Injury or other tr once.		1 Burial 2 (3 □Removel from pecify)	State	-			- 4/20/00	m:		
alti	permit. Pa Depertmen Important: any Injury		21. Signature of Fune	ral Syrviga		2.1	22	Name end Addre	ss of Fecility				Maryland
8	Depermine Depermine Supporter Suppor		Stephen D. Coster Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204									ome, Inc.	
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7	/Medical Examiner		Immadiate Ceuse (Fir disease or condition	nel	a AC	ite Muo	cardial	Infarct	ion			1	
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9	g phy es th	0	resulting in deeth) Las	st		Dua to (or as e consequ	ienca of):					
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Vital Records,	v require been si should I	ted	CNI	8)0 Dr	and hora	<i>V</i>					s en autopsy formed?	24b. W	ere eutopsy findings eileble prior to
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Division	l or Attending effer death. Director: After d in by the fune	ficat	2 ☐ Accident 3 ☐ Suicide	Investig	not bo	of Injury - At h	ome farm stre		162 Z 🗆 NO	28f Location	(Street and Numb	er or Rure	I Route Number
Ö	or Attendent efter deat Director: d in by the	Certification:	4 Homicide	daterm	build	ing, etc. (Speci	fy)	et, factory, office		City or To	wn, State)	0. 0. 1.0.0	riodio ranizo,
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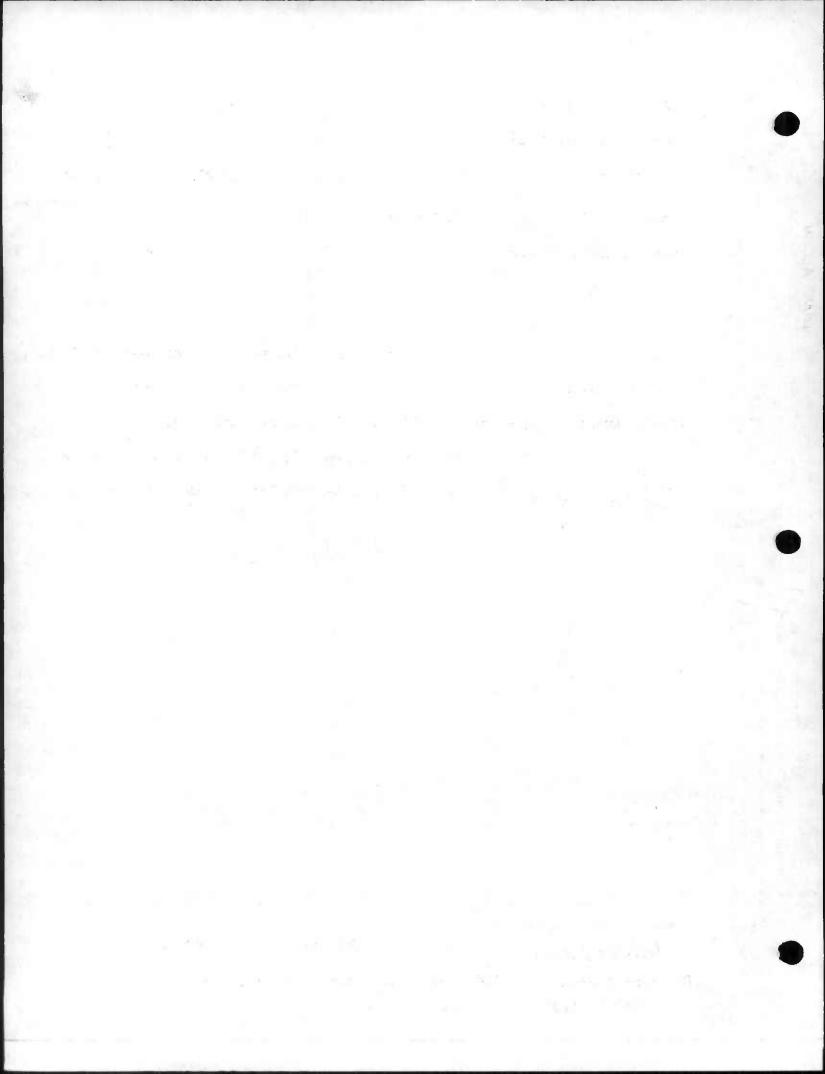
Robert Kirkwood

Division of Vital Records, P.O. Box 68768

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State of Maryland / Department of Health and Mental Hygiene 2551.

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sician	Alto	n Russel	ll Lo	na								April	18, 1	1998	6:50 A
edical miner		me (If not institut			ımbar)				4	b. City, To	wn, or Lo	ocation of Deat		y of Death	
IIIIIIei		urg Luth												Ltimo	
	5. Social Secu		6. Sa		7. Age (In yr	e last hirth	day) II	f Undar	l Year	Loch If Under				-	
rai				0 M 2□F		3. 1031 DITTI	M	Months	Days	Hours	Min.	8. Data of Bir (Month, De	y, Yeer)		placa (Steta or Fon
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	10a. Stata	10b. Coun	tv		10c (City, Town o	or Locati	ion							10d. Inside City Lin
Director			•			altimo									1 X Yes 2 □
ot o	.,,,,,					TOTILL									
Director	10e. Street and Number						10f. Zip Code						10g. Citizen of What Country?		
erail	5500 Winthrope Avenue						21214						US	SA	
Funeral	11. Marital Status 12. Was Decedent Ever in U,S Armed Forces?					U,S.	 Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexicen, Puerto 						- 14. Ra		icen Indian,
豆	1 Never Married 2 Married 1 ☐ Yes 2 No				2 No						i, i doito			ack, Whita, atc.	
by Fun	3 ☐ Widowed 4 ☐ Divorced If Yes, Give X Year or Dates:						1 Yes 2 No Specify:					Specify: white			
ह	15. Decedent's Education						16a. Decedent's Usual Occupation (Give kind of work done during most of work)						16b. Kind of Business/Industry		
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					- (C	(Give kind of work done during most of worki life. DO NOT use retired)					ng .			
E O	12					E	Electrical Technician					Baltimore Gas & El			
0	17. Father's Nama (First, Middla, Last)											e (First, Middle, Maiden Sumame)			
once. To Be Completed by	Charles E. Long											(Unobtainable)			
2	19a. Informant's Name/Relationship (Typa, Print)					10h k									
							19b. Mailing Address (Street end Number or Rural F 4583 Roundhill Rd., Elli								
	20a. Method of		II L	ong -							CTI		-		1043
		2 X Cremation	3 🗆 R	lemoval from		Place of D cematery,					14	Data /	20c. Location		
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ouce.	21. Signatur	Funeral Servic	e Lio inse	99	Λ		22. Na	ame and	Addres	s of Facili	ty				
. a	Gary L. Kaufman Funeral Home @ Meadowridge														
	23a. Part Enter the disease, or complications that caused the death. Do not enter the miner the								shi	nator	Blv	d., E1	kridge,	Md.	21075 Approximate
an	Shock, of fleath failure. List only one cause on each line.														
an	Immediate Cause (Final								or dynn), such as	cardiac	or respiratory a	11031,		Interval Between
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al er	disease or con	ndition	а		RMIA										Interval Between
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. " 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 1998 Month LEVANDOSKI AROLINE APRIL 10:26 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death SINAI BALTIMORE HOSPITAL N/A 8. Date of Birth (Month, Day, Year) Feb. 20, 1925 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Sex 1□M aX F Days Months Hours 73 Yrs. 212-22-9950 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Baltimore Co. Md. Baltimore 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 2780 Virginia Avenue 21227 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Yeer or Dates: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) William Earnest Helen Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Carol Dorn (Daughter) 2780 Virginia Avenue Balto., Md. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Burial 2 Cremation 3 Removal from State 4/23/98 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licansee Kevin E. Ecker 22. Name and Address of Facility McCully Polyniak Funeral Home Md. 21225 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 48 hours disease or condition resulting in deeth) Due to (or as a consequence of) 4 days neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pulmonony diserie obstructive moure Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown methicillin resistant saureus preumon 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy completion of cause of deeth? 1 Yes 2 No 20 No 1 Yes 26. Place of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

deeth with the Maryland

filed within 72 hours efter

n end Mental Hygiene. is marked other than "natural", or

permit. Pages 1 end 2 should be file Department of Heelth end Mental Hy important: If tem 27 is marked othe any injury or other traumatic event

Baltimore, Maryland 21215-0020

Physician/Medical Division of Vital Records, P.O. Box 6876 The law requires that the death certific signed by t Completed by peeu

certificate Hospital or Attending Physician: 24 hours efter death.
 Funeral Director: After this certifical letely filled in by the funeral director, I

edical completely within 2 To the

State Registrar

Chronic obstructive pulmonary disease (COPD) Schizo affective disorder
25. Was case referred to medical Be examiner? Certification: To 27. Manner of Deeth 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.

29b. Signature and title of cartified

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dev. Year)

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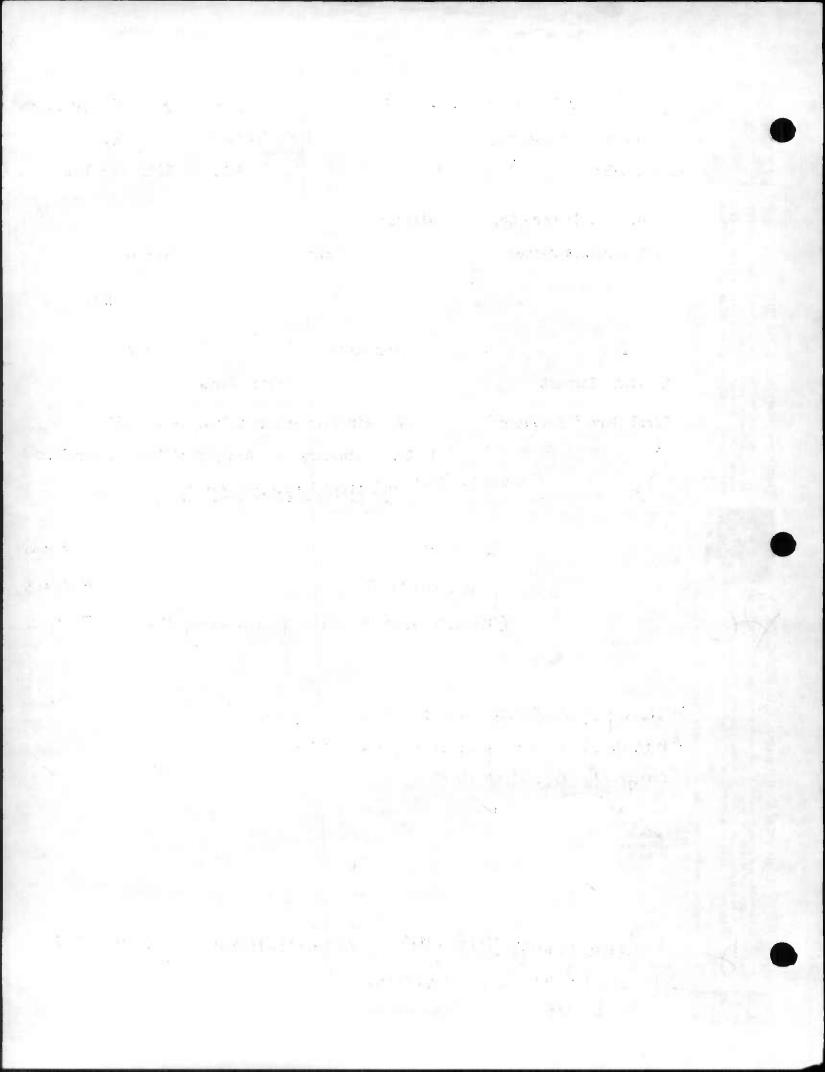
of deeth (Item 23e) (Type, Print) 30. Name and address of person

Dey, Year)

29a. Certifier

(Check only one)

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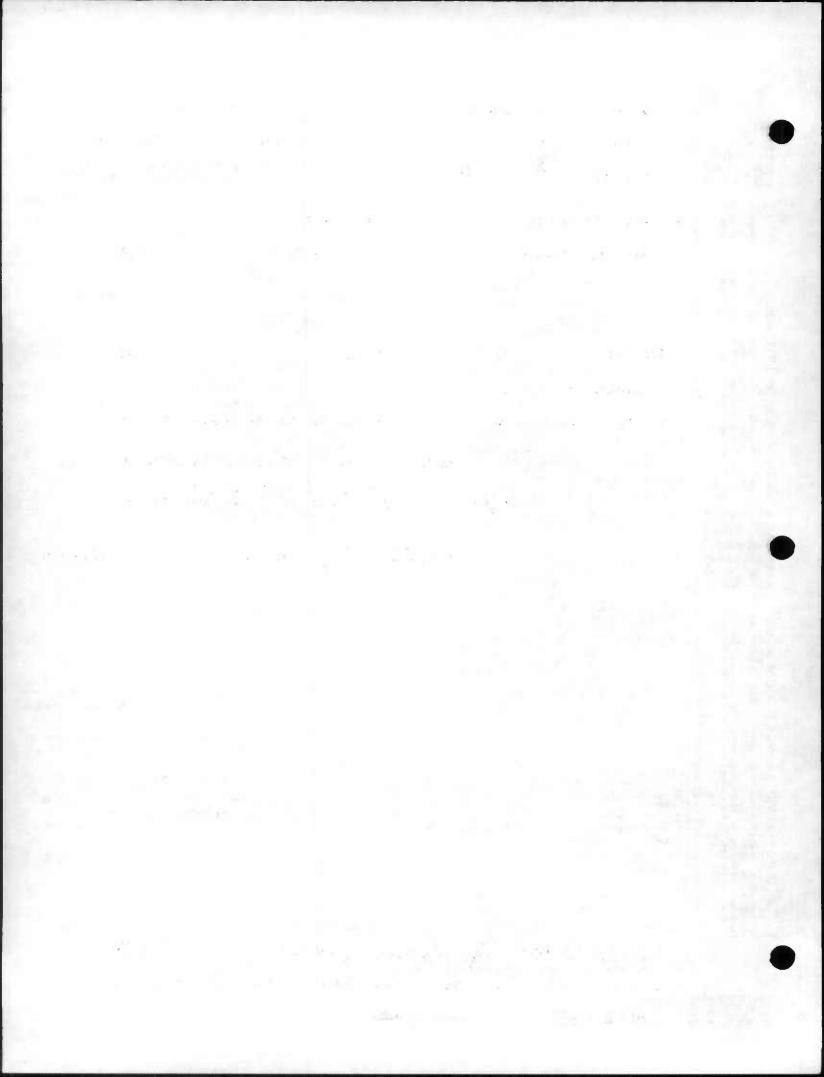
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State of Maryland / Department of Health and Mental Hygiene

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ns 23e or must be eral Di	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhet Country?	
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Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examinations. To Be Completed by Funer		12. Was Deceden Armed Forcas 1 X Yas 2 If Yes, Give Yaar or Dates	s?] No	13. Was Decedent of if Yes, specify C		? (Specify Yes or No- uerto Rican, etc.)	14. Rac Biad Specify	e - Americen Inc kk, Whita, etc.	
ted let	15. Decedent (Specify only highes	's Education	16	e. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	cupation	f working	16b. Kind of Bu	siness/Industry	
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is m	Mrs. Nancy Lis			9b. Meiling Address (Stre 3511 Hiss				1 2 3 4	")
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rtant njury	4 Donation 5 □ Other (S)		Garri	son Forest 22. Name and Add		n. 4/22/98	owings	Mills,	MU
pennin. Peges i end. Sandud ob med within 72 np Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natur any injury or other traumatic event, the Medical DRB. To Be Completed	21. Signature of Funeral Service	darly	-	Schimune	k Funer Pair Rd.	al Home, I , Baltimor	e. MV	21236	
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	metal	states lu	y ca	nee		16 M	14746
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State	31. Date filed (Month, Day, Year)	0.7	strar's Signature	1110 011	, -,	,-,	7	, , ,	

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2 Date of Death 3. Time of Death **Physician** Month PRIL CECELIA 0600 1498 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HUnder 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) OK BAUTMURE HUSPITAL 色 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2X F 218-32-0688 Director OCT. 1, 1898 MARYLAND Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MARYLAND N/A 1 Yes 2 No Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò USA 3601 FORDS LA., APT. 802 Items 23a Funeral 21215 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or language and Injury or other trauments. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be ISAAC COLDSTEIN YETTA **GEISS** 19a. Informent's Neme/Reietlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN LEVY (SON) 3903 LAKE SARAH DR. ORLANDO, FL 32804 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State HEBREW FRIENDSHIP 4/19/98 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Easility BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 etions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) **Examiner** Examiner physiciam and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Box 68760. Ò Physician/Medicai P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by the page 2 should be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 \ Homicide Certifying Physician: To the best of my knowledge, deeth occurred ef the time, dete end pleca, end due to the cause(s) end menner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 2402321-AT- 9520APRIL 17, 6998 Resident

State Registrar 31. Dete filed (Month, Dey, Year)

APR 2 1 1996

ALBERT

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Jun SINAI

HOSPITAL OF BALTIMORE

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedant's Name (First, Middla, Last) Month **Physician** 1:50A pri 4a Facility Name of not institution, give street and number) /Medical 4b, City, Town, or Location of Death Examiner Baltimore Hospital K Ho Johns pkins 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** ¥ M 2□ F Days Hours 212-84-1600 Yrs. Director Taiwan Usual Rasidence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Maryland Department of Health, and Mentel Hygiene. Inprortant: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment to another and page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Cockeysville 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10207 Sunnylake Place, Apt. C 21030 USA Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Asian p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Disabled Never Worked 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shin-Chun Liu Ruth Chang 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Hollowfield Ct. Ellicott City, MD 21043 to of Disposition (Name of Date 20c. Location - City or Town, State John C. Liu/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 04/20/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Dawn F. McDonald

23a. Parti. Enter the disease, or complications that shock, or heart failure. List only one cause on s that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, Approximate interval Between Onset and Death Physician /Medical immediate Cause (Final disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner and Hmmsit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. lar Impression 502 signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? should b Completed 24a. Wes an autopsy certificate has b 1 Yes 2 □ No 1 ☐ Yes 2 No 25. Was case refarred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No After this 28a. Dete of Injury (Month, Day Year) luneral 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after deeth. 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Director of the filled in by 3 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at tha time, deta and place, and due to the ceuse(s) and manner as stated. edicai To the Hosp within 24 hou To the Fune completely fi 2 Medical Examinar: On the besis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar

Resident Phyriain

600

32, Registrar's, Signature

N.

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

A

31. Date filed (Month, Day, Year) APR 2 1 1998

Kevin

RES-000

Wolfe St, Heyer 7-113; Baltimore, MD 21287

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State Registrar

Verter of Army Street MADE DI

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

of Maryland / Department of Health and Mental Hygiene

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			1. Decedent'a Name (First, Middle, La	st)
ı	Physicia /Medic		PPerry H. Lou	ag PEI
	Examin		4e Fecility Neme (If not Institution, giv	e street and
	-Admini	•	9616 PULASKI HWY	. ROOM
	Funeral		5. Social Security Number 6. S	
	Director		212-40-8173	¥M 2□
Н	-		Usual Residence of Decedent	
	E 8 11		10a. State 10b. County	
	Mary and ah	tor	Maryland Baltimo	ore
	h with the 23e or 28. st.be.not	al Direc	10e. Street and Number 8027 Duvall Aver	nue
	er deal	mer	11. Marital Stetus	12. Was I
0	at a support	Œ	1 Never Married 2 Married	1 D Y
02	Exa.	b	3 Widowed 4 Divorced	Year
5-0	72 hc natur disel	eted	15. Decedent's Ed (Specify only highest gra	Jucation ide complet
2121	d within pers. r than the Me	To Be Compl	Elemantary/Secondary (0-12)	Colleg
D	新元章 A	0	17. Father's Name (First, Middle, Last)	
/lan	Ald be Assistant	Lo B	Ervin Long	
ary	sho man		19a. Informant's Name/Relationship (Type, Print)
Σ	allh a		Marianna Buza/da	ughte
timore, Maryland 21215-0020	Pages 1 and Indian It		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	
Balt	permit. Departm Importa any inju		21. Signature of Funeral Service Licer Roma Ld S.	Wade,
	Physician		23a. In r1. Enter the disease, or com nock, or heart failure. List only	plicetions thona cause
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	а. Нур

Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month PPerry H. Long PERRY H. LONG APRIL 14,1998 2:40 P 4b. City, Town, or Location of Deeth 4c. County of Deeth Fecility Neme (If not Institution, give street and number) 9616 PULASKI HWY.ROOM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore County baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 53 Yrs. Nov.21, 12-40-8173 Maryland

> 10f. Zip Code 21237

10c. City, Town or Location Baltimore County 10d. Inside City Limits 1 ☐ Yes 2 K No

12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

 Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Yes 2 No Specify:

14. Race - American Indien. Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of What Country?

U.S.A.

Cab Driver

Taxicab Company 18. Mother's Name (First, Middla, Maiden Sumame)

Lyona Sigafoos

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8027 Duvall Avenue, Baltimore, Maryland 21237

20b. Place of Disposition (Name of cemetary, crematory or other place)

20c. Location - City or Town, State

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

Romald S. Wade Director

Name and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

naur

rt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line.

Approximeta Interval Between Onset end Deeth

Examine

Physician/Medicai

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Completed

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Certification:

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24 hours e Hospital

To the I within 2

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Box 68760,

P.O.

Division of Vital Records,

a Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last

C	
	Due to (or as a consequence of

Part II. Other elanificant conditions contributing to death but not resulting in the underlying causa given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of daath?

INSPECTION 1 ☐ Yes 200 No

1 Yes 2 No

25. Was cese raferred to medicel axaminer? 1 XX es 2 ☐ No 27. Mannar of Death

1 X Natural

2 Accident

4 Homicide

3 Suicide

5 Pending investigation 28a. Data of Injury (Month, Day Year)

1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yas 2 No

Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

6 Could not be datarmined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only one)

20h Si

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APRIL 15,1998

and addrass of parson who complated cause of death (item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)
APR 21 1998

32. Registrar's Signature

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Funeral Director the Maryland 10a State d 2 should be filed within 72 hours after deeth with the Manylan In and Mental Hygiena. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, me Medical Engine Insults not led at traumatic event, me Medical Engine Insults and the contents of the Medical Engine Insults or the Medica Directo Maryland Funeral 11. Marital Status 114, Edward by Completed Peges 1 end 2

21085 300 Belfast Court 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 6/2/41 If Yes, Give Year or Dates: 11/29/42 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 20 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 12 yrs. n/a Electrical Engineer 17. Fether's Name (First, Middle, Last) George Cromwell Lilly Amelia Nixon 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 end 2:
Department of Health at
Important: If Item 27 is
any injury or other trau (Wife) Doris B. Lilly 300 Belfast Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Dentsville Cemetery 22. Name and Address of Facility
E. F. Lassahn Funeral Home 21. Signature of Funeral Service Licens 23a. Pert1. Enter the dise of corn lications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final · Aspiration disease or condition resulting in death) Examiner Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. Artery Disease Completed by tate Cancer nis certificata has b 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this funerel 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 1 Natural 5 ☐ Panding within 24 hours efter death.

To the Funeral Director: Af 1 Yes 2 No Investigation 2 Accident 6 Could not be datamined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida

32. Registrer's Signature

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:16P.M toril Edward L. Lilly /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death Examiner Baltimore Rosedale Hospital Center Square tranklin If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, May 5, 1 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Deys Yrs 1915 220-01-4452 Baltimore City, Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Harford Joppatown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business/Industry ITT Corporation 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Joppatown, Md. 21085 20c. Location - City or Town, Stata 4/18/98 LaPlata, Maryland 11750 Belair Road Kingsville, Maryland 21087 5 days 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings avellebla prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifies 29c. License number 188870 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) 9000 Franklin Square. Dr. Sheena Antonio

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2560

Reg. No:

Registrar

State

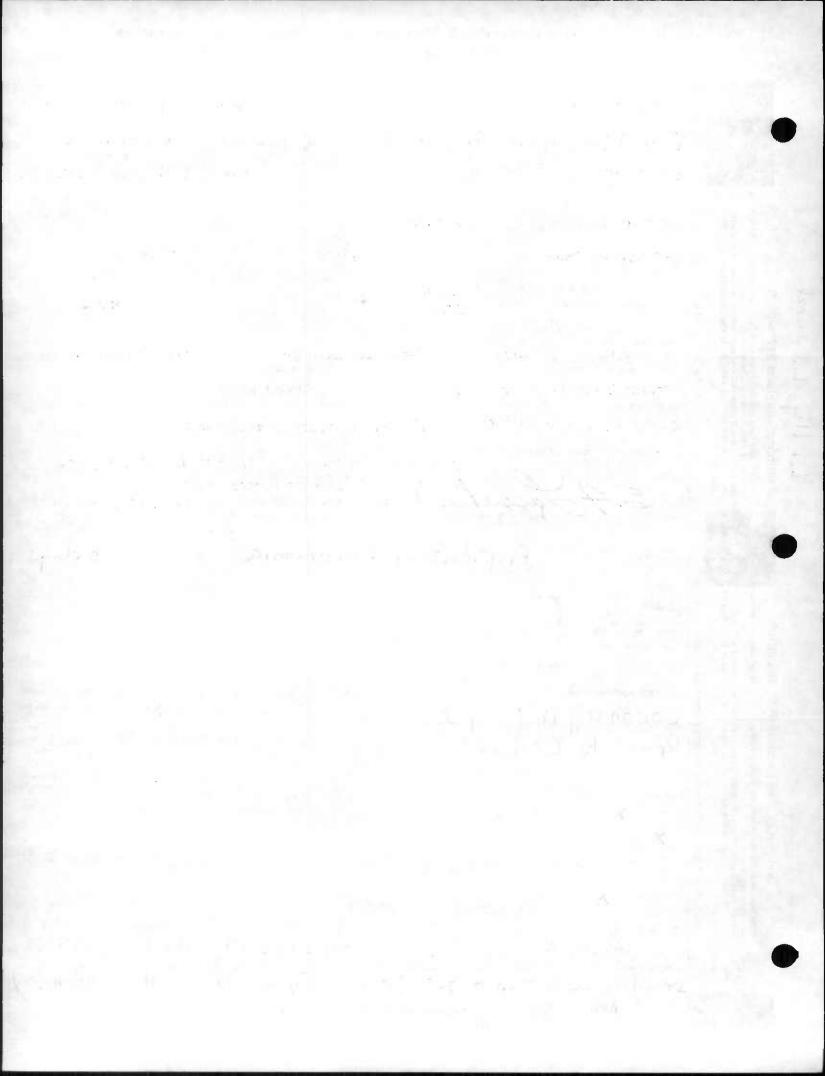
within 2

The law requiras that the death certificate be precuted

or Attending Physician:

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Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Defe of Deeth **Physician** Month >55 ORIL /Medical 4e. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** RANKFORD NURSING CENTER N/A 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Months Deys 1 □ M 2 X F 216-32-0125 80 Yrs Director June 17, England Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland 1 X Yes 2 □ No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 5019 Pilgrim Road items 23a 21214 United States Funerai 12. Was Decedenf Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, tra Medical Examina 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Saleslady Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be (Unknown) (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Clarence H. Little /Bro.inLaw 5011 Pilgrim Road Baltimore, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Parkwood Cemetery 4/21/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Funerei Service Licensee Mark T. Zavoyna 22. Name end Address of Fecility 5305 Harford Road 7. Baltimore, Md. 21214 23a. Part1. Enter the disee of a cardiac or respiretory errest, shock, or heer feilure. Let only one cause on each line. **Physician** /Medical Immediate Cause (Final 4 HOURS 20 disease or condition resulting In death) **Examiner** Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest P.O. Box 68760, The law requires that the death certificate to s certificete hes been signed by the a director, page 2 should be detached f Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 ☐ Unknown Division of Vital Records. þ Be Completed 245. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? After this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? 26. Piece Death (Check only one) 1300 60 Other: 4 ursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 | No 2 Accident 6 ☐ Could nof be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) and menner stated? 29a. Certifier

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DRU State Registrar

(Check only one)

29b. Signatury and title of certifier

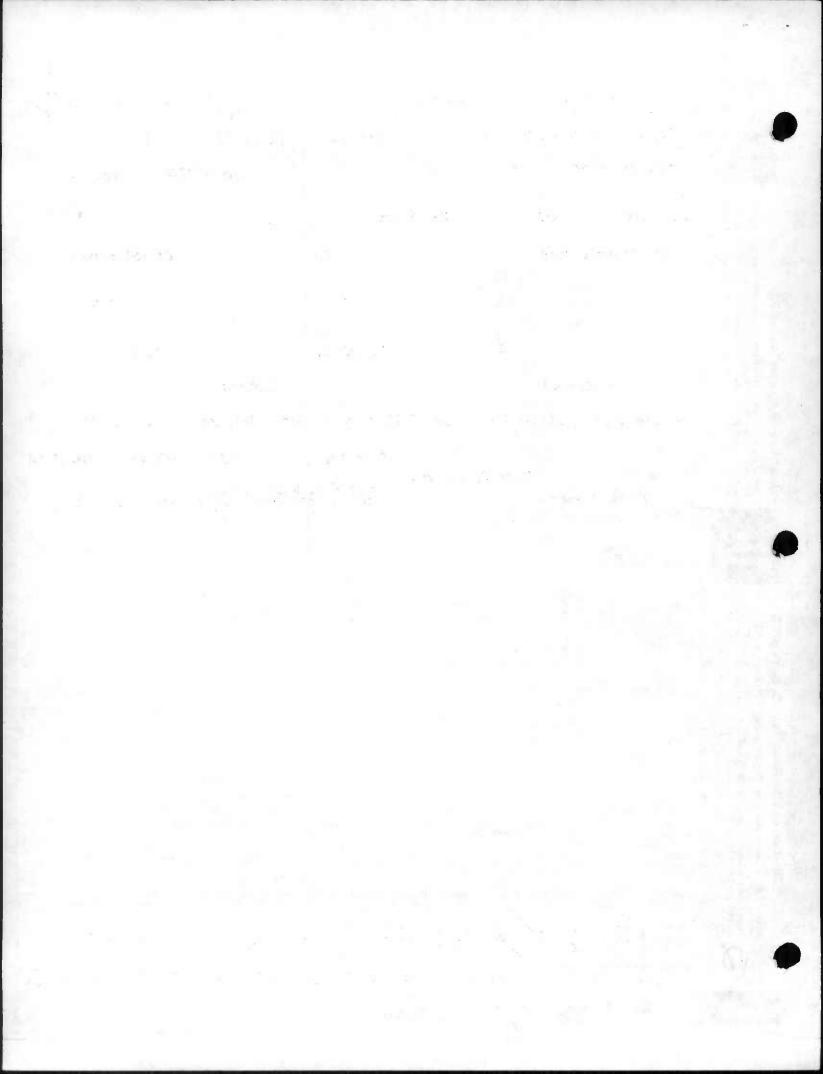
31. Dete filed (Month, Dey, Yeer)

32, Registrer's Signeture

29c. License number

51 HOCABIRD AVE.

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					Ce	rtificate of	Death		Reg. No.		1.001
ysician	1. Decedent's Nama	(First, Middle,	Last)					2. Date of De	eath Day_	. Year	3. Time of Oslati
Medical	Mildred	Eileen	Long					Honi	19	1992	1 7-PI
aminer	4e Fecility Neme (If	not institution,	giva street end m	ım <i>bar</i>)			4b. City, Town, or L	ocasion of Deat	h 46. Coun	nty of Deeth	
	Stella 1	Maris					Timoniu	ım	Ва	altime	ore
ral	5. Social Sacurity Nu		. Sex	7. Age (In y	rs. lest birthday)	If Under 1 Yaar		8. Date of Bi (Month, Di	rth	9. Birth	plece (Stete or Fore
or	216-07-2 Usual Rasidenca of D		1□ M 2점 F		78 Yrs.	Months Deys	Hours Min.	Apr. 20	1919	M	aryland
		10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Lin
6	Maryland	Balt	imore		Timo	nium					1 □ Yes 2 🔀
Director	10e. Street end Num	hor				10f. Zip Coda			10g. Citizen o	of What Cou	intry?
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Funeral	11. Maritel Status	_	Armed F	cedent Ever in orces? 2 1 No	10,5.	If Yes, specify Cub	Hispenic Origin? (Sp an, Mexican, Puert	Rican, etc.)	B	leck, White	
by F	1 Never Marrie		If Yes, G	iva		1□ Yes 2₺ No	Specify:		Spec	oify:	White
0	3 € Widowed 4	Divorced	Yaar or i	Dates:							
ele		 Decedant's y only highest; 	Education grede compieted)	16a. Dace (Give	dent's Usuel Occu kind of work done	petion during most of wor ad)	king	16b. Kind of	Business/I	ndustry
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5	10				Secr	retary					of Balti
Be	17. Fether's Neme (F	First, Middle, La	ist)				18. Mother's Nan	ne (First, Middle	, Maiden Sum	eme)	
10	James M.	Donnel	lv				Sarah	J. By	cne		
	19e. Informent's Ner				19b. Maili	ng Address (Stree	t and Number or Ru			vn, State, Z	ip Code)
	Mr Joh	n T. T.O	ng (Son)	1	P.O.	Box 111	Newcomb,	Marvlar	nd 2165	3	
	20a. Method of Dispo		ng (bon		. Place of Dispo	sition (Neme of		Dete	20c. Location		Town, Stete
			Removal from	Slate H		metory or other ple Service C	orp. 4/	21/98	Towson	n Ma	ryland
	4 □ Donetion 5		11	4		2. Nama and Addr	4 50 100				
Medical Examiner	Sequentielly list confidency, leading to immorause. Enter Under Ceuse (Disease or lift that Initiated avents resulting in death) Leading in death) Leading in death)		c		o (or as e consec		ardiol	dsevi	brDi	seds	2:
Physician/M	Part II. Other signific	eant conditions		death but not i	rasulting In the u	inderlying cause g	ivan in Part I.	23b. Dio	i tobacco uae	contribute	to the cause of de
by Phy	Res	not	e X	oke	cton	4-00	ncer	1	Yes 2□ No	3 □ Pr	obably 4 1 Unik
Completed t	y	Lus	7		/			24a. We per	s en eutopsy formed?	6	Nere eutopsy findir eveileble prior to completion of cause of daeth?
Eo			/					1 🗆	Yes 2ENo		Yes 2□ No
	25. Wes case referre	ed to medical					26. Pleca of Dec				
w w	examiner?		Hospital:	Inpatient 2	☐ ER/Outpetie	nt 3 DOA O	her .	oma 5□Res		Other /Soc	rifu)
o Be	1 LY45 2 1 K			of Injury	28b. Time o				how injury occ		
2	1 ☐ Yes 2 ☐ N 27. Mannar of Death			nth, Dey Year) Injury		ork?]Yes 2□No				
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10	27. Mannar of Death	Investiga	tion (Mo		t home, ferm, st			28f. Location	(Street end Nu	mber or Ru	ral Route Number
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DHMH 16 Rev 6/95

JULY WESTER FORES and the first transfer and the last and the system of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Royston Cordell Madary, Sr. 14, April 1998 5:30 P.M. 4e. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Deeth 4c. County of Death Howard County General Hospital Columbia If Under 24 Hrs. Hours Min. Howard County 6. Sex 1X M 2 F If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1905 Mary Land 5. Social Security Number Deys Yrs 217-09-3899 92 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6312 Orchard Road 21090 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Police Elementary/Secondery (0-12) College (1-4or 5+) Unknown Police Patrolman Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Nicholas Madary Kate Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Herget, Jr. (Grandson) 7974 Crownsway Glen Burnie, Maryland 21061 1 Disposition (Name of Date 20c. Location - City or Town, State 20e. Method of Disposition 1 IX Buriel 2 ☐ Cremation 3 ☐ Removel from State 20b. Placa of Disposition (Name of cametery, crematory or other place) Glen Haven Memorial Park 4/17/98 Glen Burnie,Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Kevin E. Ecker McCully-Polyniak Funeral Home 21. Signature of Funeral Service Licensee 237 E. Patapsco Ave., Balto., Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown dements 24a. Was an autopsy performed? teo poro sis

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

þ

Completed

2

Funeral

Director

item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be not lised at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Hema 23s any Injury or other traumatic event, the Medical Examiner mans.

3altimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

with the Marylend

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Physician/Medical 8

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Completed

Be

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Certification:

Medical

certificate

After this

ne Hospital or Attending P n 24 hours effer death. ne Funeral Director: After t

within 2 ş

funerai

31. Date filed (Month, Day, Year)

APR 2 1 1998

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 30 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28e. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 3 Suicide

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

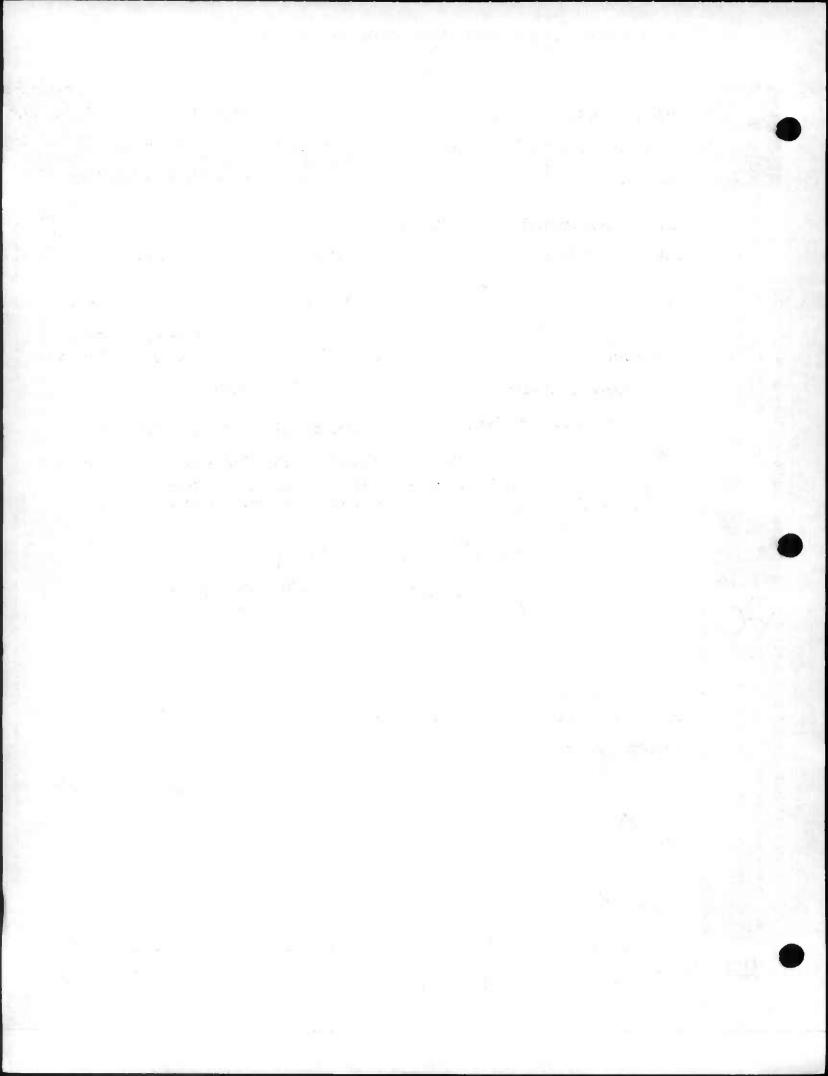
Peninsula FarmRd Arnold MD

State Registrar

32. Registrar's Signature

Funa Davidson Randalle

21012

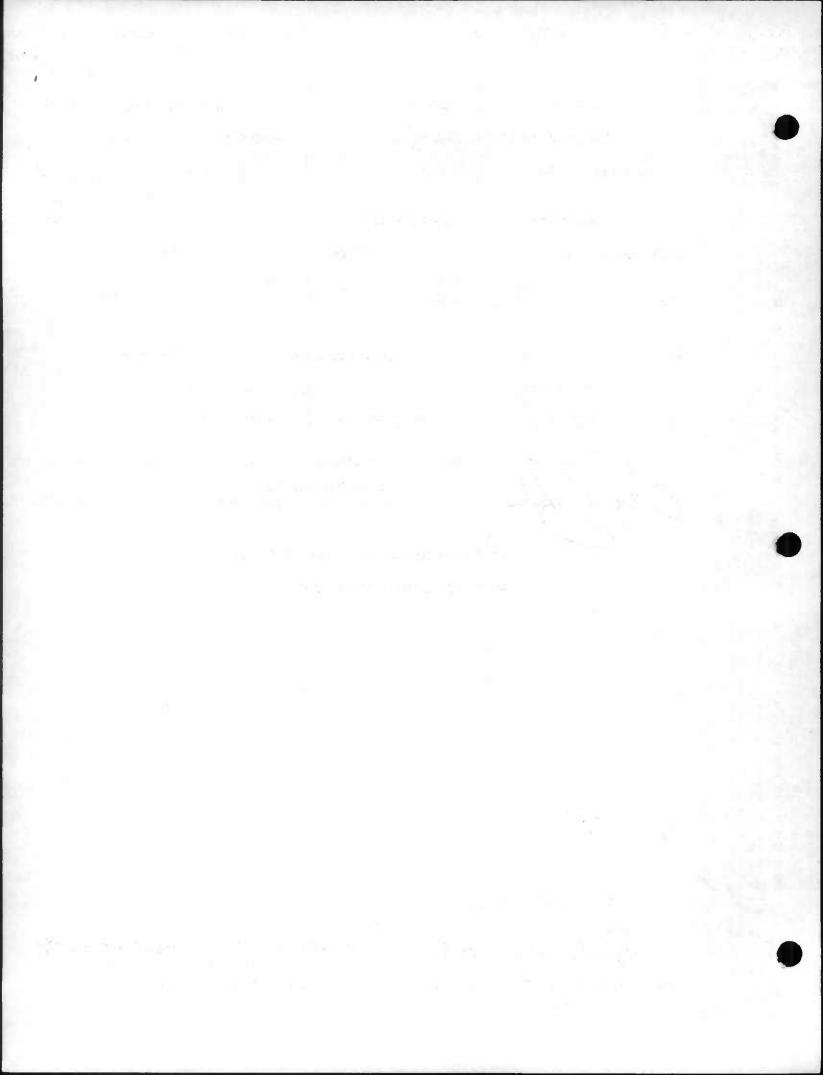


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | 256

						Cen	illicate	of	Death			Reg. No.		,		
Physician /Medical		Decedant's Nema (First, Midd THON			MITC	HELL					2. Date of De Month APR	ath	19	Year 98		of Death
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Funeral Director		5. Social Security Number 207-14-0537 Usual Residance of Dacedant	6. Sex		71	birthday) Yrs.	If Undar 1 Months	Year Deys	If Under: Hours	24 Hrs. Min.	8. Dete of Bird (Month, Da Feb. 27		7	9. Birthpla Countr Penns		a o <i>r For</i> eig an i a
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21. Signature of Funeral Service Acenses					22. Nama and Address of Facility Fleck Funeral Home, Inc 7601 Sandy Spring Road,								.1	Mow. 1	t	2070
hysician /Medical Examiner	-	Immedieta Causa (Fina disaesa or condition resulting in daath)	a	(VENTR	a consequ	ence of):			UPTU	RE				Jiset al	nd Deeth
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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental thygiene. In: If item 27 is marked other than "natural", or ite iny or other traumatic event, the Medical Externines

permit. Page Department of Important: If any Injury or

Physician /Medical

Examiner

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Hospital

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Certification:

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Director

Funeral

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Completed

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death

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State o	f Maryland /	Department of Health and Mental	Hygiene
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I1	ems: 23 part I,27	per MEO G-759	5/7/98 reb <i>Ce</i>	rtificate of	Death	Re	g. No.
Physician /Medical	1. Decedent's Nama (First, Mic		R MILBUI	RN		2. Dete of Deet Month APRIL	h Day
Examiner	4a Facility Name (If not institut				4b. City, Town, or Lo		4c.
	WASHINGTON	COUNTY HO	SPITAL		HAGERS	STOWN	W
Funeral	5. Social Sacurity Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yea Months Days		8. Date of Birth (Month, Day,	Year)

1998 3:16 PM. County of Death

ASHINGTON Birthplaca (Stata or Foraign Country) Hours 8. Date of Birth (Month, Day, Year) Days

219.50.4343 Usual Residenca of Decedent 10a. Stata

10b. County 10c. City, Town or Location

1 M 2 F

MAY 30, 1950 MARYLAND 10d. Inside City Limits

MARYLAND 10e Street and Number BALTIMORE 10f. Zip Code

1 Yas 2 No 10g, Citizen of What Country?

2565

3. Time of Death

11, Marital Status

DUKELAND STREET

College (1-4or 5+)

21216 Was Decadent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☑ Divorced

12. Was Decedent Evar in U,S. Armed Forces? ☐ Yes 2 No Yes, Give Year or Dates:

1 Yes 2 No Specify: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BLACK 16b. Kind of Business/Industry

U.S.A

15. Decedent's Education (Specify only highast grede completed) Elementery/Secondary (0-12) 12 th

COOK - CHEF

RESTAURANT

17. Fether's Nama (First, Middle, Last)

GEORGE HENRY GHEE MARY ELIZABETH ROANE

18. Mother's Name (First, Middle, Maiden Sumeme)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

PATRICIA JAC085 (SISTER) 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

7018 PARK HEIGHTS (0.4) BALTIMORE MD 21215 Date 20c. Location - City or Town, Stata

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

MOUNT ZION 22. Nama and Address of Facility 4-16-98 MARYLAND

mald a Graysur

RONALD A. GRAYSON FUNERAL SERVICE 3511 MILIVALE ROAD BALTIMORE HARYLAND 21244

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart lailure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in daath)

CORONARY ATHEROSCLEROSIS, FOCALLY SEVERE, WITH OLD THROMBOTIC OCCLUSION Due to (or as e consequence of):

Due to (or es e consequenca of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted avents resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 ™ Unknown

24e. Wes en eutopsy

24b. Were autopsy findings evailable prior to completion of causa of deeth?

15€Yes 2 No

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 28a. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

1 Yes 2 No

26. Place of Death (Check only one)

28e. Placa ol Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

(Check only one)

DONMLA

29a. Certifie

27. Menner of Death

1XX Neturel

2 Accident

3 Suicida

4 Homiclde

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner as stated.

**Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

G,

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) 12, 1998 APRIL

Nonald & Wright MD

5 Pending

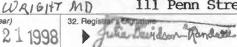
investigation

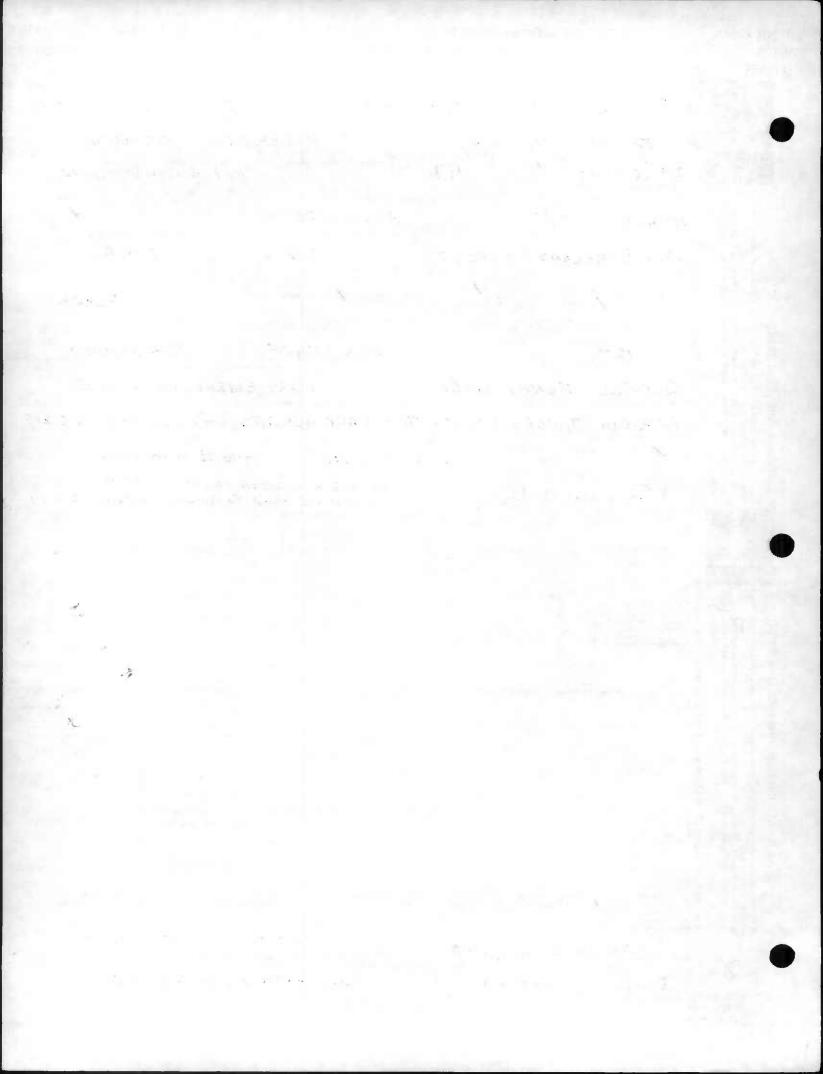
6 Could not be determined

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date liled (Month, Dey, Year) APR 21





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

							Cert	ificate d	of L	Death			Reg. N	0.0	16	200	
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Physic /Medi			M	ary E.	McCa	nn						Hori	1	9 1	998	3:39	m
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21215-0020 3 within 72 hours after peres "natural", or it	by	1 ☐ Never Merrie 3 ☒ Widowed		1 Tes If Yes, G Year or i	Ž∭ No live Dates:		10	Yes XX	No	Specify:				Specify	. Whi	te	
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7/7		30. Name end eddre	ess of person who	completed car	ise of de	eth (Item 23a)	(Type, P	rint)	0	~		00	1			1998	
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DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, MAtthews amil 4c County of Death 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Hospital more If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 6. Sex If Undar 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) Months Days 579-94-4263 Usuel Residence of Decedent 1⊿M 2□ F a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No MORE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race -1 Never Marriad 2 Married 1 ☐ Yes 2 Z No If Yes, Give Yaar or Dates: 1 ☐ Yes 2 ☑ No Specify 100 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1,4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) unic unc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Hamilton Cathedral ALTIMORE MD 21215 20c. Location - City or Town, State guardian 1000 20e. Met/fod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pace) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ansdowne, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen BAIN, MD21217 Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown ·MRSA 24b. Were eutopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy parformad? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

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Funeral

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permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or the any injury or other traumetic event

been signed by the attending physician end should be deteched for use as the burnal-tran P.O. Box 68760 Hospital or Attanding Physician: The law requires that the death certificete De 24 hours efter death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records,

Physician/Medical ģ Completed Be 1º

Examiner

To the Hospital or Attandin within 24 hours effer death.
To the Funeral Director: Af completely filled in by the fu

BOUVAY, MD State Registrar

29b. Signature and title of certifier

25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Medicai Certification: 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year)

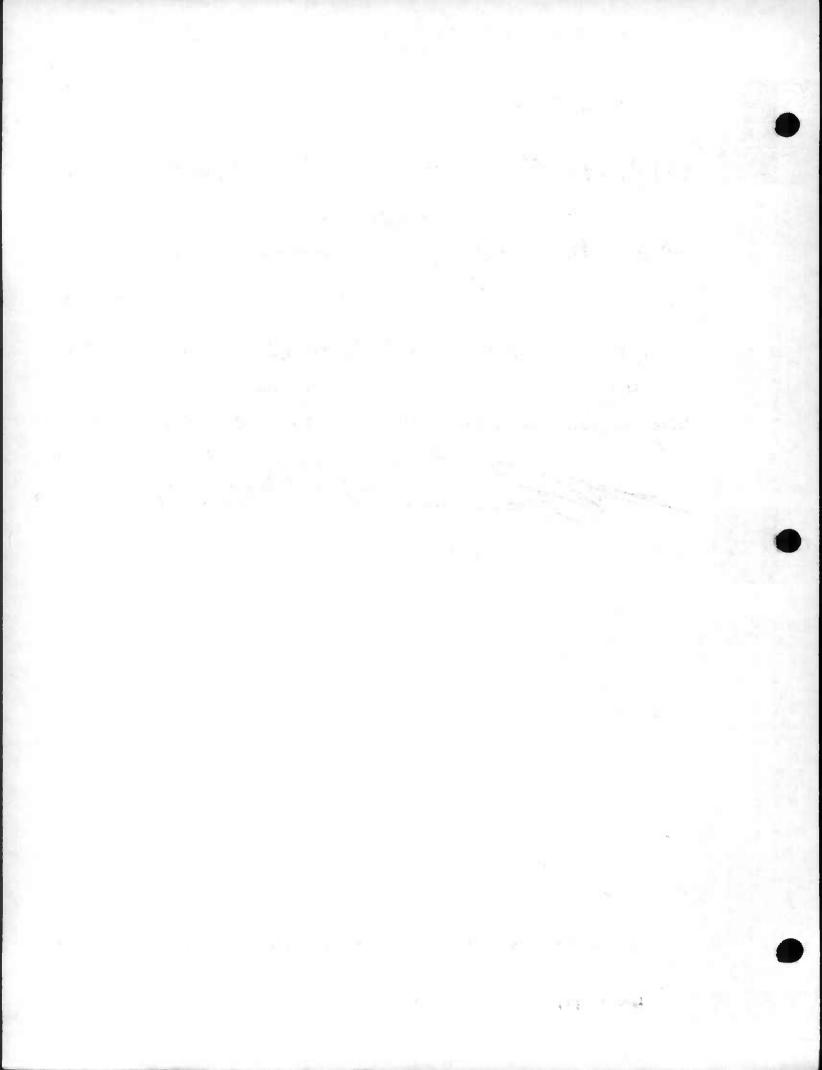
M. FOUNDAK

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. Belveder Ave Paulinone 2401

32 Registrarie Signature

Funda Navidon-Randate



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death (SIXTERN) 1. Decedent's Name (First, Middle, Last) **Physician** Megenharat Veronica 08:32 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mercy Medical Center Baltimore Baltimore | Months | Days | Hours | Min. | State of Birth (Month, Day, Year) | June 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2₩F Maryland 65 Yrs. 218-28-3133 Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinating must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Dundalk Director Baltimore Maryland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. of America 7871 St' 21222 Fabian Lane death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours affer to Department of Haatth and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic avail. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎖 ☐ No Specify: ρ Specify: White 3 ☐ Widowed 5€ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Food Market 12 Cashier NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gornawicz Buzgierski Catherine William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3416 Loganview Dr. Baltimore, Md. 21222 Fred A. Baumgardner L (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20 Baltimore, Maryland Holly Hill April 21. Signature of Fyneral Service Lic 22. Name and Address of Facility Dabrowski-Chojnacki F.H.P.A. 1005 Dundalk Ave. Baltimore, Md.21224 Mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. ter the disease, or complication heart failure. List only one car **Physician** /Medical Immediate Cause (Finel Cerebral Vascular Accident week disease or condition resulting in deeth) Examiner Artey Occlusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac Breast Carcinoma 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings avaitable prior to completion of cause of death? Hypertension 24a. Was en eutopsy performed? Be Completed this certificata has 1 ☐ Yes 2 XNo Division of Vital 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completaly filled in by the funera 28b. Time of 28d. Describe how Injury occurred After t Medical Certification: 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

P12005

29d. Date signed (Month, Day, Year)

State

Registrar

29b. Signal of and title of certifie

3537 Kingston Cout, Ellicoft City, MD 21042 31. Date filed (Ma 32. Registrar's Signature

M.D.

ceuse of deeth (Item 23e) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month . **Physician** DRIL Mario J. Marconi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) **Examiner** HOSEDA. If Under 24 Hrs. 8. Center PITAL FRANKLIN Le BALTIMORE HOS MARE It Under 1 Year Birthplece (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min. 1 € M 2 □ F 89 Yrs. 215-32-0045 Director 11, 1908 Italy Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1□Yes 2□No Director Maryland Baltimore Dunda1k 10f. Zip Coda 10g. Citizen of Whet Country? 10e, Street and Number r than "natural", or lisens 23a or the Medical Examiner must be 21222 1932 Midland Road United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 20 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Self Employed-Shoe Repair Shoe Repair 8 years marked other 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Montal Annunziata Compelli Diego Marconi 19e. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9 Item 27 Jennie Marconi (Wife) 1932 Midland Road Dundalk, Maryland 21222 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Buriel 2 ☐ Cremetion 3 ☐ Removal from State St. Stanislaus Cemetery 4/20/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee 22. Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Shock /Medical Immediate Cause (Final disease or condition resulting in deeth) ARDIOGENIC Examiner Physician/Medical Examiner physician end the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): that initiated events resulting in deeth) Last Dua to (or as e consaquance of): 23b. Did tobacco use contribute to the cause of death? ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by a 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy tindings available prior to completion of causa of death? been si 24a. Was an autopsy Completed is certificate has b 2 No 2□ No 25. Wes case reterred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 1 A Natural 2 ☐ Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Dey, Year)

FRANKLIN SQUARE DY BALTO MD 21237

The law requires that the deeth certificete be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: s after deam. al Director: After th within 24 hours after To the Funeral Direcompletely filled in b

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Pages 1 and 2 should be filed within

State

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29a. Certifier (Check only one)

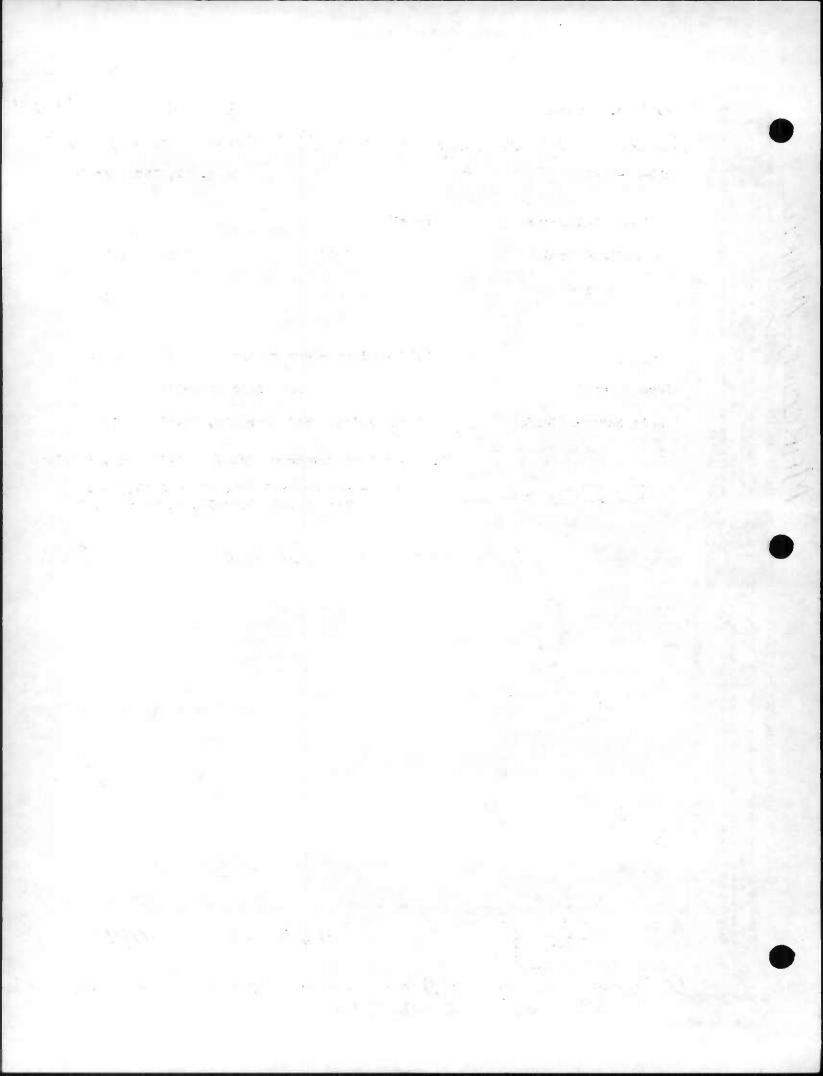
29b. Signatura and titla an contil

30. Name end eddress of person who completed ceuse ot death (Item 23a) (Type, Print)

1998

who Davidson

Registrar



	HARLES ELSON A	men	nd: item #10a Per Anat				tificate of	lealth and I Death	vierilai H	ygiene Reg. No.	1	2570
	Physicia		1. Decedent's Name (First, Middle, Li	est)			1 - 4 - 1		2. Dete of D Month	Day	Year	3. Time of Deeth
	/Medic	al	Charles Thoma		iel.			4b. City, Town, or I	APRIL	12, 19		10:40A.M.
A	Examin	er	4a Facility Name (If not Institution, gir FRANKLIN SQUARE I		(r)			ESSE:		BALTI		
	Funeral Director		5. Social Security Number 6.	Sex 7. A	Age (In yrs. las 46	ot birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.		irth (Pay, Year) 19,1951	9. Births	place (Stete or Foreign ntry) yland
	death with the Maryland ima 23a or 28e-f show ima the incitted at	tor	10a. State 10b. County	ore City		Town or Local Limo					1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	23e or 28	rai Director	10e. Street and Number 4237 Shamrock Av	enue			10f. Zip Code 21206			10g. Citizen of U.S.A.	What Cour	ntry?
020	urs efter	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If If Yes, Give Yeer or Dates	s? No	If	Vas Decedent of H I Yes, specify Cub I ☐ Yes 2 1 No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		ce - Americ ck, White, y: Wh:	etc.
21215-0020	within 72 ho iena. than "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	ducation ede completed) College (1-40)		(Give I		pation during most of wor d)	king	16b. Kind of B		dustry
	Hygie Hygie officer the	8	12 17. Fether's Name (First, Middle, Las	4		5	ergeant	18. Mother's Nen	ne (First, Midd	Police		
Maryland	Mental Mental or artic eve	To Be	Roy Linwood Ne.					Nan Wil				
ary	2 should be and Mental is marked c	-	19a. Informant's Name/Reletionship	(Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Num	ber, City or Town	, State, Zip	Code)
	1 end 2 Heelth a am 27 is		Lucy Strausl	oaugh/wife	2	4237	Shamroc	k Avenue	Balti	more, Ma	rylar	nd 21206
altimore,	Page nent o ant: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		CAR	ca of Dispos	sition (Name of natory or other pla		Date	20c. Location		
	Physician /Medical Examiner	ner	23a. Part. Enter the disease, of consideration, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	u mee	ed the deeth. line. C ARRYT Due to (or a	Do not ente	Baltimor er the mode of dyi	e, Maryla	ind 212	01	CIMOI	Approximate Intervel Between Onset and Death
Box 68760,	eeth certificate be executed ettending physician and for use as the burial-transit	Physician/Medical Examine	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest	c	Due to (or a							
P.O.	d by the datached		Part II. Other significant conditions CARDIAC TRANSPLAN		but not resulti	ing in the ur	nderlying cause giv	ven in Part I.				o the cause of death
Division of Vital Records,	aw requires is been sign 2 should be	Completed by							INSP	as an autopsy formed? ECTION	av cc of	ere autopsy findings vallable prior to mpletion of cause death?
ta	ician: The cartificata rector, pag	BeC	25. Was case referred to medical					26. Place of Dea				
<u> </u>	ysici is car direc	ToB	examiner? 1∑ Yes 2 No	Hospital: 1 Inpa	tient 2 XEF	R/Outpatien	t 3 DOA Oth	nor:		sidence 6 🗆 Ott	her (Specia	fy)
sion o	Attending Physician: r death. ector: After this cartific by the funeral director,	Certification:	27. Menner of Death 1 XX atural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	A	Day Year)	8b. Time of Injury		ry et rk? I Yes 2 □ No		e how injury occu		
<u>></u>	al or At s after of I Direct of in by	Sertif	4 Homicide determined	289. Place of I	njury - At hom etc. (Specify)	e, ferm, stre	eet, factory, office			(Street and Num. own, State)	ber or Hun	ei Houte Number,
	he Hospi in 24 hou he Funer pletely fill	edicai		nysician: To the bes miner: On the basis and manner:	of examination							
	To the Total	Σ	29b. Signature end title of certifier Debugle &	& whis	do Ma	0	29c. Licens	.M.E.		29d. Dete signe APRIL 1		
			30. Name and address of person who Donald G. Wright	completed cause of		3a) (Type, I		Street,	Baltim	ore, Mar	yland	1 21201

State * Registrar

31. Date filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) April 19 199 8 aar **Physician** 7:25 PM Genevieve M. Neely /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Rosedale Ba
If Undar 24 Hrs.
Hours Min.
Apr, 8
1904 Franklin Square Medical Center Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday Baltimore Birthplaca (Steta or Foreign Country)

M
d If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 M 2 F 212-36-1453 94 Director Usual Residence of Decedant deeth with the Marylend 10c. City, Town or Location 10a Stata 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at Md. 1 ☐ Yas 2 ₹ No Rosedale, Baltimore Directo 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number USA 21237 Road 4806 Ridge Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 14. Raca - Amarican Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer a Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other terms. Black, Whita, atc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify þ 3 Widowed 4 □ Divorcad White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Home Homemaker 10th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Hnknown Stefert John 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 4806 Ridge Rd., Baltimore, Md. 21237 Raymond E. Neely 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 12 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Spacity) Baltimore Cemetery 4/23 Baltimore City 22. Nama and Addrass of Facility
Hartley Miller Funeral Home, CHTD. 21. Signatura of Funarai Sarvice Licensaa 7527 Harford Rd. Baltimore, Md. 21234 23a Part. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical tmmediata Causa (Final disaase or condition rasulting in daath) Apterioscleric CARDIOVASCULAT disease Examiner Physician/Medical Examiner Apterry promany Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or Injury that Initieted events rasulting in deeth) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the ferdenscon Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa given in Part I. 1 Yss 2 No 3 Probably 4 Unknown signed b à 24b. Wara autopsy findinga available prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 s hes 1 Tyas 2 KNo 1 ☐ Yas 2 ☐ No certificate Hospital or Attanding Physician: director, Be 25. Wes case referred to medical axaminar? 28. Place of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funerei 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. tnjury at Work? 1 Naturel 5 Panding ofter death. Director: Aft 1 Yas 2 No invastigation 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 24 hours e 1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, date end place, and dua to tha ceusa(s) and mannar as stated.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. edicai 29a. Certifiar To the Hosp within 24 hor To the Fune completely fi 29d. Data signed (Month, Day, Yaar) 29c. Licansa number 29b. Signatura and tile of certifiar April 20, 1998 D 35410 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Liya Pfeffer, 6918 Ridge Rd., Baltimore, Md. 21237 M.D. 32. Registrate Signature Sundan Randall State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#26 per Phy G758 4/17/98 EW 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 P.M. March Gerda rymerman ID /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor

If Under 24 Hrs.

Vaurs Min.

B. Date of Birth
(Month, Day, Year)
D2C, 9,1929 Baitimore 8641 Willow Kd. Oak If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Days 68 Yrs. 216-26-7162 Germany Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or itema 23s or 28s-f ahow any Injury or other traumatic event, the Medical Experies must be northed at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8641 Willow 21234 Oak Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1□ Yes 2 No altimore, Maryland 21215-0020 Specify: White Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Food Stove Cleaner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Vec Alam aske Albert 19a. tntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Hagerstown, MD 21746 18701 Koxbur Boris 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Locetion - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3-23-98 Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home Stallings 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. MD 21122 Pasadena, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner hysician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last requires that the death certificate be axec Division of Vital Records, P.O. Box 68760, physician Monu Physician/Medicai USB as t for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were eutopsy tindings available prior to 24e. Was en autopsy periormed? Completed completion of ceuse of death? paga 2 has 1 ☐ Yes 2 No 1 Yes 2 No certificata or Attending Physician: funeral director. 25. Was cese reterred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 2 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient STE LICIA After this 28a. Date of Injury (Month, Day Year) 27. Manger of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and,manner stated.

cause ot death (item 23a) (Type, Print) 6730

32. Registrals sighan

29c. License number

29d. Date signed (Month, Day, Year)

Holabird Ave., Baltimore, MD 21222

State Registrar

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Medical

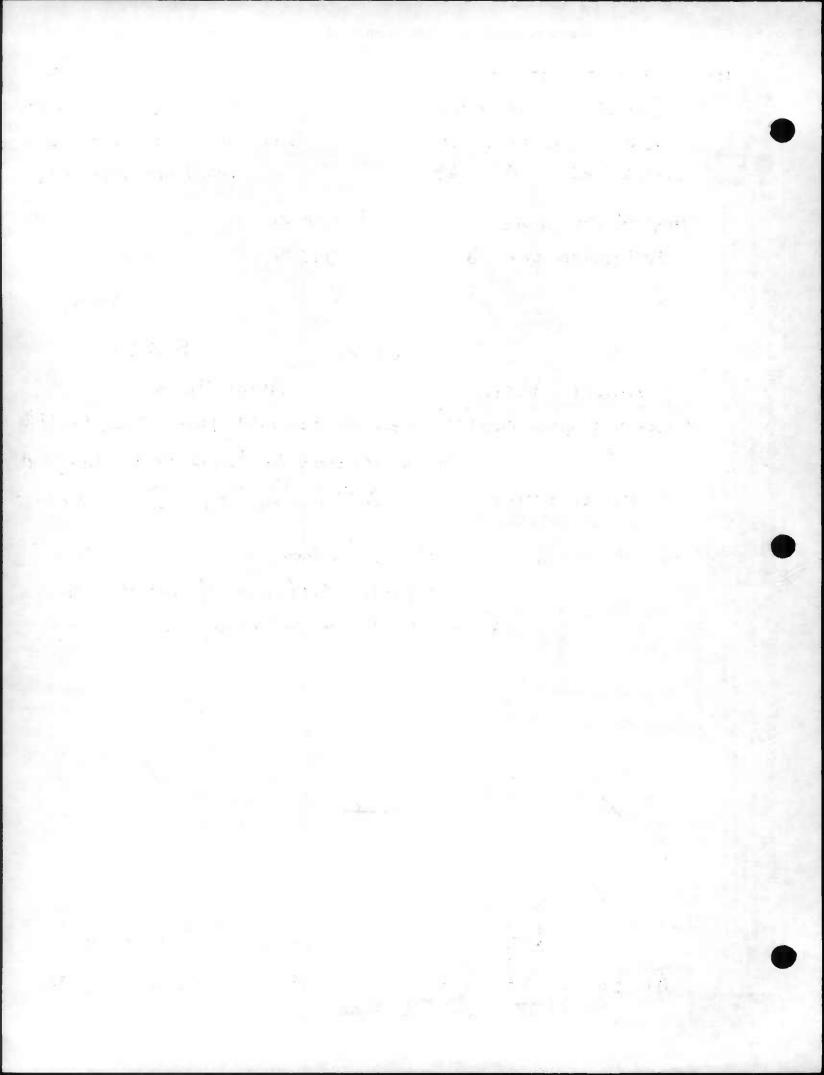
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29b. Signature and title of certifier

30. Name and address of person who complete

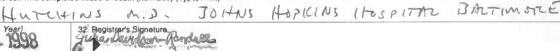
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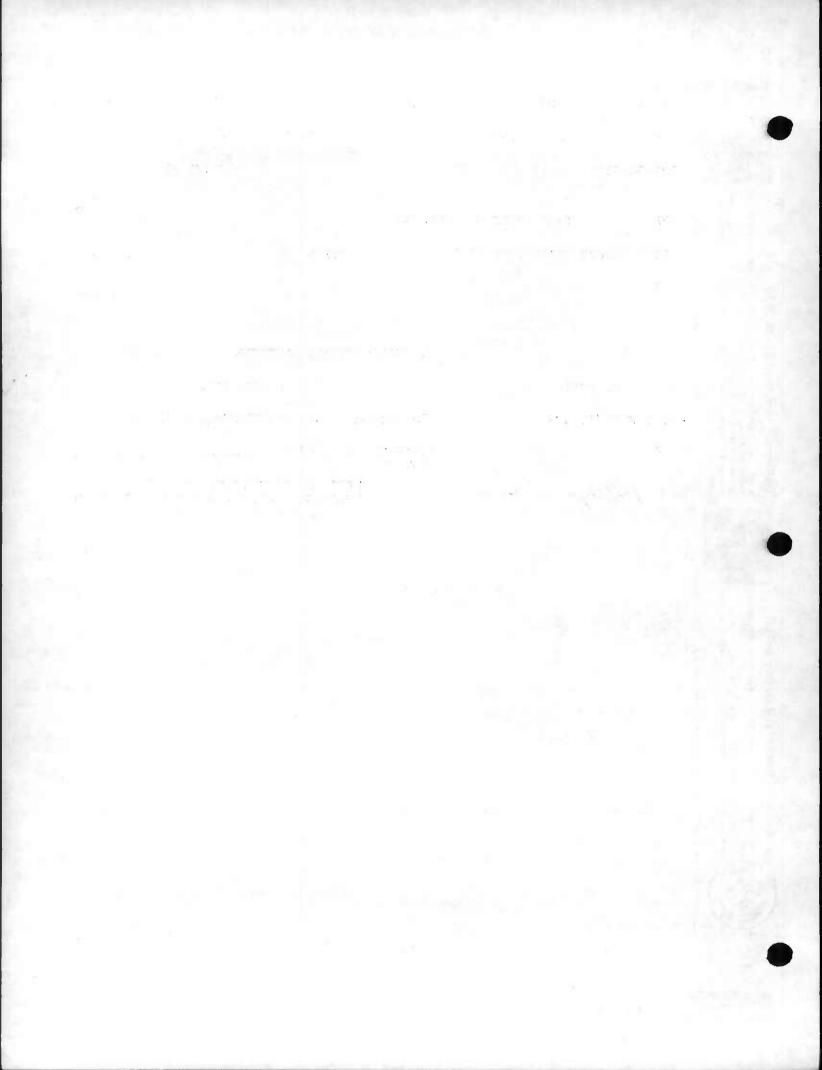
R°21 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 1998 16ay 04:50PM MICHAEL RALPH PEEL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Under 1 Yaar 8. Date of Birth (Month, Day, Year, 03/29/1961 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F Months Days Hours 37 Yrs. 181-58-5109 Director Usuel Residence of Decedent the Maryland 10a. Stata 10h County 10c. City, Town or Location 10d. Insida City Limits Pages 1 end 2 should be filed within 72 hours efter death with the Marylar nent of Health and Mental Hygiene. Int: If Item 27 Ia merked other than "netural", or Items 23a or 28a-f show ary or other traumetic event, the Medical Examinar must be not trained. MXYes 2□No Director PRINCE WILLIAM MANASSAS 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 11184 RIENZI PLACE COND #101 20109 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14 Race - American Indian Black, White, etc. 1 DXNever Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 21XNo Specify Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SENIOR SOFTWARE ENGINEER 12 4 COMPUTER 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be LESTER C. PEEL CAROL MANES 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL PEEL/MOTHER 105 McELREE ROAD WASHINGTON. PA 15301 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State WASHINGTON CEMETERY & permit. Page Department o Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 4/22/98 WASHINGTON, PA CREMATORY 21. Signature Inneral Sarvice Licensee 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as e consequence of): elitu 7/-5pine Examine physician end s the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last vision of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 88 950 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? deteched Carcinome - metestatic 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24e. Was en eutopsy performad? Completed completion of cause of death? certificate has b 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Physician: 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No P 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funerel 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number AUT HOW! 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

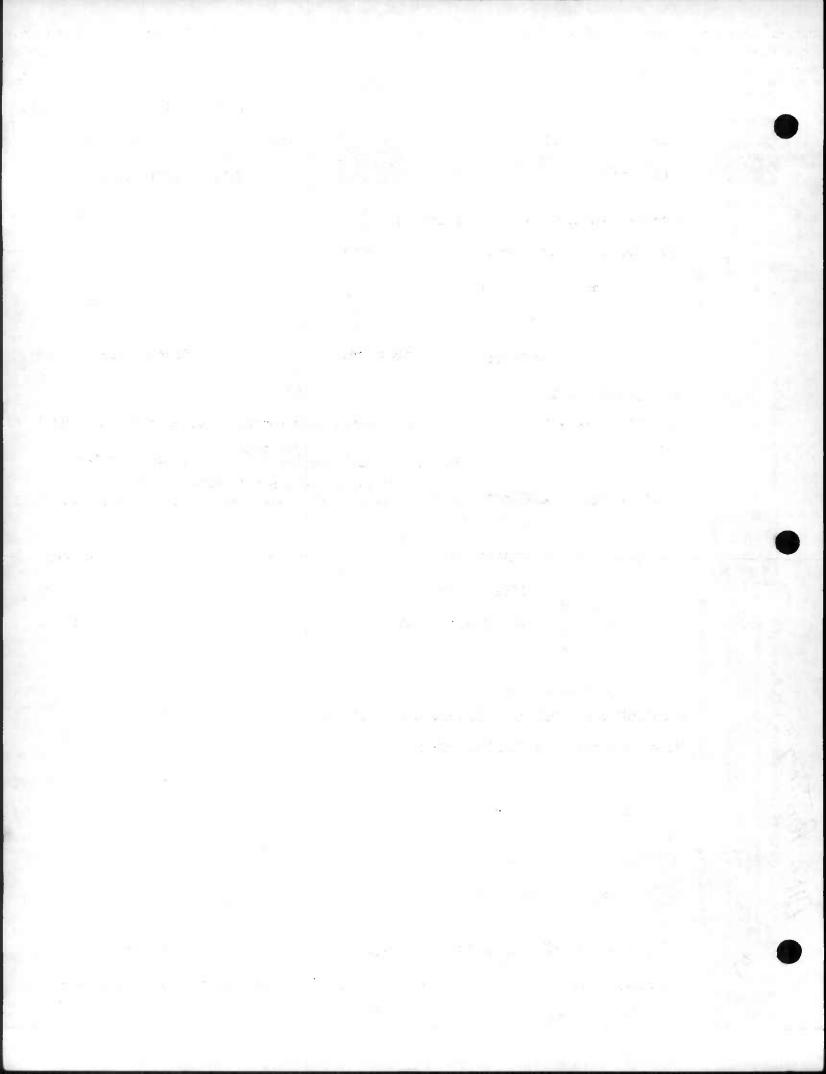




State of Maryland / Department of Health and Mental Hygiene

12574

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			Suburban Hospit	al					Bethe				tgome	ery
	Funerai Director		5. Sociel Security Number 212-49-6730 Usuel Residence of Decedent	. Sex 1 □ M 2 2 F	7. Age (In yrs. 66	lest birthday) Yrs.	Months D	Yaar Deys	If Under 24 Hi Hours Mi				9. Birthi Coul Ukra	plece (Stete or Foreign htry) aine
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	or 28	Jrec.	10e. Street and Number				10f. Zip Co				10g.	Citizen of V	Whet Cou	ntry?
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Maryland 21215-0020	or he	by Funeral Director	Never Merried 2∑Married Widowed 4 □ Divorced	Armed Fo	2 ∰ No ′e		Was Deceden If Yas, specify 1 ☐ Yes 2 [x]		lispenic Origin? (an, Maxican, Pus Specify:	Specify Yes or I into Rican, etc.)	No-		k, White,	
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Division of	after des Director d in by th	Certification:	3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homlcide determine	ad 286. Piece	of Injury - At ho	ome, farm, str	eet, factory, o	ffice		28f. Location City or 1			er or Run	ral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) XXCertifying 2 Medicat Ex	Physician: To the aminer: On the be end menr	best of my know esis of exeminet her steted.	wledge, deeth	n occurred et t vestigation, in	the tin	ne, dete end ple pinion, deeth oc	ce, end due to the	ne ceus e, date	e(s) end me end place,	enner es e end due t	steted. to the ceuse(s)
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	3		30. Name end eddress of person wh	o completed caus	e of deeth (Item	23e) (Type,	Print)							
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)	Exami		4e. Fecility Neme (If not institution, give					4b. City, Town, or L		h 4c. County	of Death		
			5. Sociel Security Number 6. S	THUREN N			nder 1 Yea	BALTIM If Under 24 Hrs.		N	A		
	Funeral Director		215-01-7812D 1 Usuel Residence of Decedent	□ M 28 F	yrs. last birt	frs. Mor			8. Date of Bir (Month, De	9, 1912	9. Birthple Counti	eca (Stete or Foreign	
	Maryland -f show	tor	10a. State 10b. County		c. City, Town	or Location					10	d. Inside City Limits	
	or 28s	irec	10e. Street end Number			*	. Zip Code			10g. Citizen of	Whet Count	ry?	
	th will	<u>a</u>	3715 GIBBON	SAVE			9	11214		U.S.A			
20	72 hours after death with the Maryland "naturel", or tems 23e or 28a-f show cost Examinet Living to multiple at	y Funeral Director	11. Maritai Status 1 Never Merried 2 Married	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	r in U,S.	If Yes,	acedent of specify Cul	Hispenic Origin? (Sp ben, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - America ck, Whita, a	tc.	
5-0020	hours urel',	d by	3 Vidowed 4 □ Divorced	Yeer or Detes:	1.0						WH		
215	in 72 in at	Completed	15. Decedent's Ed (Specify only highest gre	de completed)	160.	Decedent's (Give kind o lifa. DO NO	f work done	during most of work	orking 16b. Kind of Busin		usiness/Indu	istry	
212	e filed within all Hygiene. other than "	mo	Elementery/Secondary (0-12)	College (1-4or 5+)			tome	MAKER		HOME			
	be filed within 72 ho tal Hygiene. d other than "natur event, the Medical	Be C	17. Fathar's Name (First, Middla, Last)		,			18. Mother's Nam	e (First, Middla				
aryland		2	Louis H. AP	PEL	F			MARTH	M At	OELLE	R		
Mar	U 42 80 80		19e. Informent's Name/Relationship (7				Iress (Stree	et end Number or Rui			Stete, Zip (Coda)	
	other tr		MR JOHN PHALLI 20e. Method of Disposition		Ob. Place of			EY AVE	BALTO		1334		
altimore,	of of		1 Deurial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	MOREL	, crematory	or othar pie	ETERY 4	22 98	BALTO	.MD		
Ball	permit. Pag Department Important: i any injury c		21. Signeture of Funeral Service Licen	S 99			e and Addr	ass of Facility	ILLER	FUNE	RAL H	TOME	
_	205 2		Tartley N	relle !		752		111		ALTO. N		1234	
	Physician /Medical Examiner		23a. Perti. Enter the disease, of companions, or heert feiture. List only of the companions of the com	. END STI		ALZH	EIM				i	Approximete nierval Between Onset end Deeth	
7	d d d	Examiner	Sequentially list conditions	b. — — — — — — — — — — — — — — — — — — —	to (or es e c	neenuence	of):						
o,	20	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	540	10 (0) 03 0 0	onsoquence	01).						
9/89	ate by	lical	Ceuse (Diseese or Injury that Initiated events resulting in daath) Lest	cDue	to (or as a co	onsequence	nce of):						
	death certificate be attending physical of for usa as the b	Mec		d									
ROX	ath ca attend for us	lan/		u									
	that the d ed by the detached	by Physician/Medica											
ecords,	aw requi	Completed b								en eutopsy ermed?	evei	e eutopsy findings lebie prior to pletion of cause seth?	
T	0 - 0	mo.							10	Yes 2 No	10	Yes 2□ No	
VITAI	ysicien: The secretificate director, pag	Be	25. Wes case referred to medical exeminer?					26. Plece of Deet	h (Check only o	one)			
0	F 40 73	2	1 ☐ Yes 2 ☑ No		2□ ER/Out		DOA		oma 5□ Resid	dance 6 Oth	ar (Specify)		
	if or Attending Phy i after death. I Director: After this d in by the funeral of	ation:	27. Manner of Deeth 1 Neturel 2 Accident 5 Pending invastigation	28e. Dete of Injury (Month, Day Yea	28b. Ti	me of jury M	28c. Inju Wo	ryet ork?]Yas 2 □ No	28d. Describe	how injury occur	red		
DIVISION	s after de i Directe ed in by t	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S	At home, far	m, street, fe	ctory, office		28f. Location (: City or Tox	Street and Numb vn, Stete)	er or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical (29a. Certifier 1 ☐ Certifying Phy (Check only one)	relcian: To the best of my lner: On the basis of exe end menner steted.	knowledge, minetion end	deeth occur or Investiga	red et the tilion, in my	ime, date end plece, opinion, deeth occur	end due to the red et the time,	cause(s) end me deta and place,	enner es ste and dua to t	ted. he ceusa(s)	
	To the To the comp	M	29b. Signeture end title of certifier)				sa numbar		29d. Data signe			
	1		I Neborah I St	ierce			H45	931		APRIL 1	8,19	98	

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DEBOKAH I PIERCE 7220 PARK HEIGHTS AVENUE BALTIMORE MD

32. Regis Sundon-Randelle

State Registrar DEBOKAH I PIERCE

31. Data filed (Month, Day, Year)

APR 2 1 1998

PRINCIPLE TO SELECTION OF THE SECOND TO SELECT THE SECOND TO SECO rest 47 juille He

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth EDRGE 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth GOOD SAMARITON HOSP. BALTIMORE 7. Age (In yrs. lest birthday) Yrs. If Under 1 Yeer | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 157-03-2197 10M 20 F Days Hours Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Çity Limits MID NIA 1 Yes 2 No BACTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6228 FALKIRK Road. 21239 4.5. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1□Yes 2 No Specify: BLK 3 NWidowed 4 □ Divorced 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CONSTRUCTION RIGGER 6 -0 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) NEELE JOSEPH 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 5008 PLAINFIELD AVE. BACTIMORE, MD. 21206 GEURGE CHAMBERS (NEPhEW) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Bemoval from State LINDEN, N. J. ROSE 4111 CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility E. L. PHILLDS FUNERAL HOME -21. Signeture of Funeral Service Licensee 1721-27N. MONEGE ST. BACTIMORE, MD Z1217 ruta Okch CFSP 23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dylng, such es cardlac or respiratory errest, shock, or heert failure. List only one ceuse on each line. LEFT LOWER WAS PNEUMONIA Immediete Ceuse (Final diseese or condition resulting in death) NON SMALL CELL CARLINOMA OF THE WING Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown HY PERTENSION 24e. Wes en eutopsy performed? 24b. Were autopsy findings evaileble prior to completion of cause of deeth? 1 Yes 2 - No 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

and

physician a

rigned by

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Attac

Director:

Physician/Medical

Completed

Medical Certification:

Box 68760,

P.0.

Division of Vital Records,

Physician

/Medical

Examiner

10a Stete

Funeral

Director

28a-f show

Director

þ

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after teporatment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Exerctions.

Baltimore, Maryland 21215-0020

death with the Maryland

Sequentielty list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

END STAGE RENAL DISEASE

OR PULMO NALF 25. Wes case referred to medical exeminer?

1 Yes 2 No

28e. Date of Injury (Month, Dey Yeer) 5 Pending investigation

6 Could not be 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital: 1 Inpatient 2 ER/Outpetlent 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

27. Manner of Death

1 Saturet

3 Sulcide

2 Accident

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

29b. Signature and title of certifier

cause of deeth (Item 23e) (Type, Print) GOD SAMMITAN

GiME

State Registrar

higher than the state of the st Mineral Control of the Control of th in a Steel of St. Inc.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#31 per DVR G758 4/21/98 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year 98 **Physician** Month VONNE /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Dea **Examiner** MEMORIA, BALTIMORE
If Under 24 Hrs. 8. De 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) **Funeral** Deys Hours 250-64-381 1 M 2 1 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 1 Yes 2 No Director ALTIMORE 10e. Street, and Number 10g. Citizen of Whet Country? 10f. Zip Code 5 70 4 Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ID No If Yes, Give Year or Detes: Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours effer (
Department of Health and Mentel Hygiene,
Important: If item 27 is merked other than "naturel", or han 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ₩idowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give/kind of work done during most of working life./DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 1AGGIE NONES AMES 19a, Informent's Name/Reletionship (Type, Pript) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 704 Aughten KATHERINE 20c. Location - City or Town, Plece of Disposition (Name of cemetery, crematory of other pla 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHEKRI 21. Signetyre of Funerei Service Licensee 22. Name end Address of Fecility Muneuere MONROEST. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Betw **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner ettending physician and for use es the buriel-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last P.O. Box 68760 Physician/Medical signed by the 6 Pert fl. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of desth? ale No 3 Probably 4 Unknown 1 Yes Records, þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? is certificate hes been si director, page 2 should Be Completed 24e. Wes en eutopsy performed? 2/2 No After this certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physicien: 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ A 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No fector: in by the 3 Suicide 8 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 T Homicide 29e. Certifier Medical Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

E. UNIVERSITY

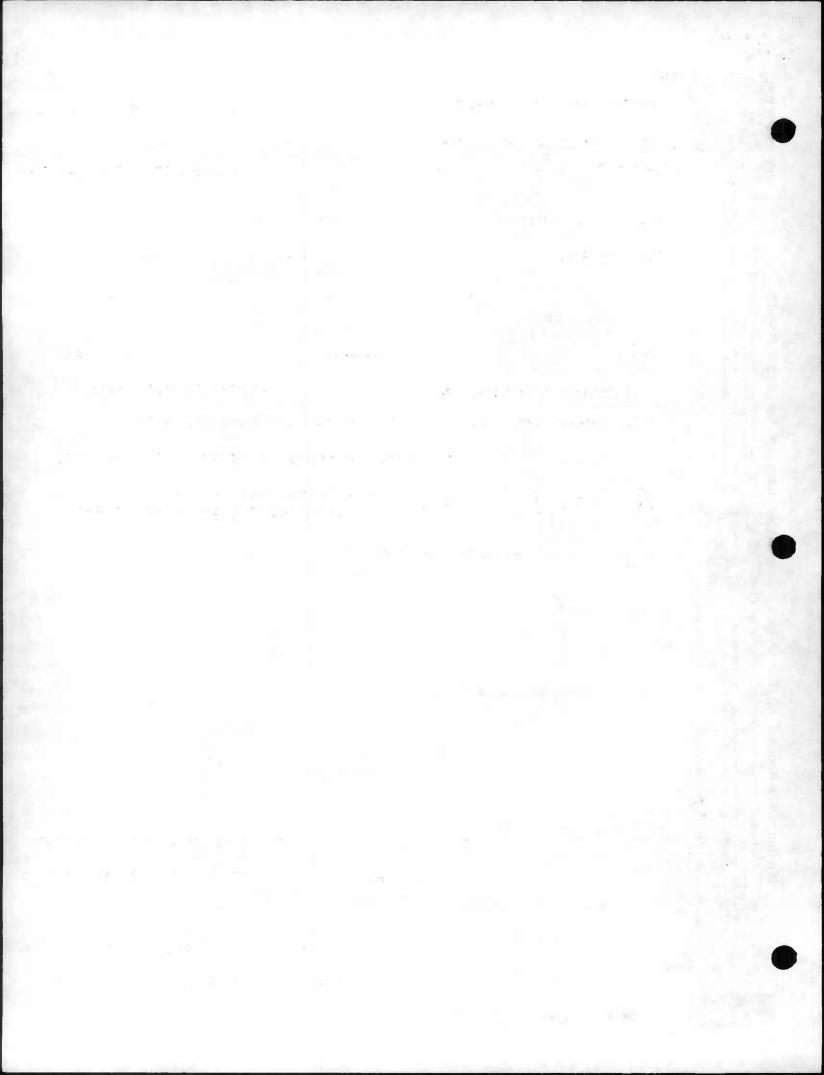
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30. Name and address of gardon who completed ceuse of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day,

-088 ROBERT P.	PU	RKEY		State	of Maryla				lealth ar Death	nd Me		giene Reg. No.		2578	
Physiclan /Medical	1	ROBERT	PATE	RICK P	URKEY	180-180			b. City, Town		APRIL	Dey 15,19		3. Time of Death 8:45A.M.	
Examiner		e Fecility Name (#ROUTE 152				D			JOP		ation of Deett	HARI	y of Death		
Funeral Director		Social Security Nu 218-04-93	mber 6	Sex 1 M 2 F	7. Age (In yrs	lest birthday)	if Under Months	r 1 Year Days	If Under 24		Month, Da Feb. 8			place (State or Foreign nty) IthCarolina	
Pu »		Isuel Residence of I	Dacedent 10b. County		100.0	ity, Town or Lo	cation							10d. Inside City Limits	
Maryla f sho		Md.		timore	100.0	ity, rount of Lo	oution	Esse	×					1 ☐ Yes 2 💢 No	
r 28s	1	0e. Street and Num					10f. Zip					10g. Citizen of	What Cou	ntry?	
th with	2	1113 MAG	ce Ave.						21221			USA			
ours after death with the Marylar sal, or items 23s or 28s-f show Examiner must be notified at the Funeral Director	ny ruile	Maritaf Status Never Marrie Widowed Maritaf Status		Armed F	2 No		Was Dece f Yes, spe l ☐ Yas		ispanic Origin an, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or No ican, etc.)	Ble	14. Race - American Indian, Bleck, White, etc. Specify: White		
n 72 hc	Danielle	(Special Elemantary/Second		grade completed)) (1-4or 5+)		kind of wo DO NOT u	ork dona ise ratired	du <i>ring</i> most o	f working	7	16b. Kind of E			
be filed tal Hygi d other svent, I		7th 7. Fether's Name (F	First, Middle, La	st)	Carpenter 18. Mothers						First, Middle,	Meiden Sume		rution	
should be filed within of Mental Hygiena. marked other than imatic svent, the Manal Comp	9	C1i	inton Ro	bert Pu	rkev Jr				Je	anne	ette P	atricia	Bark	cer	
2 should and Men is marke- aumatic		9a. Informant's Na	me/Relationship	(Type, Print)	,	19b. Mailir			e <i>nd</i> Number	or Rural	Route Number	er, City or Town			
1 and Haalth em 27 ther tr		Clinton		Purkey					e. Bal	time		- Crat-			
pemnit. Pagas 1 and Department of Haalth important: If item 27 any Injury or other to once.	2		Cremation 3	☐Removal from	State	Place of Dispo cemetery, crer			Date	20c. Location - City or Town, State 8 Baltimore Md.					
permit. Pagas Department of Important: If it any injury or c ance.	-	4 ☐ Donation !			0		n Ce		ery	4/1	8/98	Bait	mor	е ма.	
permit. Departmental Importal sny inju		DO -	-	//	/	1/10	onne	111	Fune	ral	Homo	of E	v		
death cartificate be executed e attanding physician and indicate as the burial-transit if can use as the burial-transit if can we have a second or a s	TVallillo	23a. Part1. Enter the shock, or heart mmediate Ceuse (Fiseasa or condition esulting in death) Sequentially list contany, leading to immediate Ceuse (Disease or Inat Initiated events seulting in deeth) L.	ditions, mediate lying njury		PIPLE Dua to (INJURIE (or as a consector es e consec	ES juance of) juence of)	:					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Onset and Death	
auth certification attending for usa as												to the serves of death?			
tha y		art II. Other signific	cent conditions	contributing to d	isulting in the underlying ceuse given in Part I.						Yes XXNo		bably 4 Unknown		
aw requise been 2 should										-	PARTI		a co	Vere autopsy findings veilable prior to ompletion of ceuse daath?	
E # E C		5. Was cese rafarre	ad to modical						00.51		1)(1)		1	¥Yas 2□No	
Physician: Tha I this cartificate he ral director, page	3	examiner? 1 ☑ Yes 2 ☐ N		Hospital:	Inpatient 2	☐ ER/Outpatier	t 3□ D	OA Oth	or.		(Check only o		thar (Spec	(v) SCENE	
4 4 4		7. Manner of Death 1 Naturel 2 Accident	5 Pending	28a. Dete (<i>Mor</i> 4/15	of Injury oth, Dey Year) /1998	28b. Time of Injury 7:52		28c. Injur Wor		28	3d. Describe	now Injury occu	irred	COLLISON	
C E D		3 Suicide 4 Homicida	6 Could not determine	289. Plac	28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) ROADWAY						City or To	vn, Stete)		val Route Number, VILLE ROAD	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2			Physician: To the aminer: On the b											
Within To the comp		9b. Signeture end t	itie of certifier	1001			29	c. Licens	e number			29d. Date sign	ed (Month	Day, Year)	
				V 42	_			0.0	.M.E.		P	PRIL 1	6,199	8	
		0. Name end eddre DAVID R.F	OWLER M	1.D.			111	Pen	n Stre	et,	Baltin	ore, M	aryla	nd 21201	
State Registrar	1	1. Date filed (Month	n, Day, Year)	18 32. J	egistrar's Sign	lon-Rand	lell								



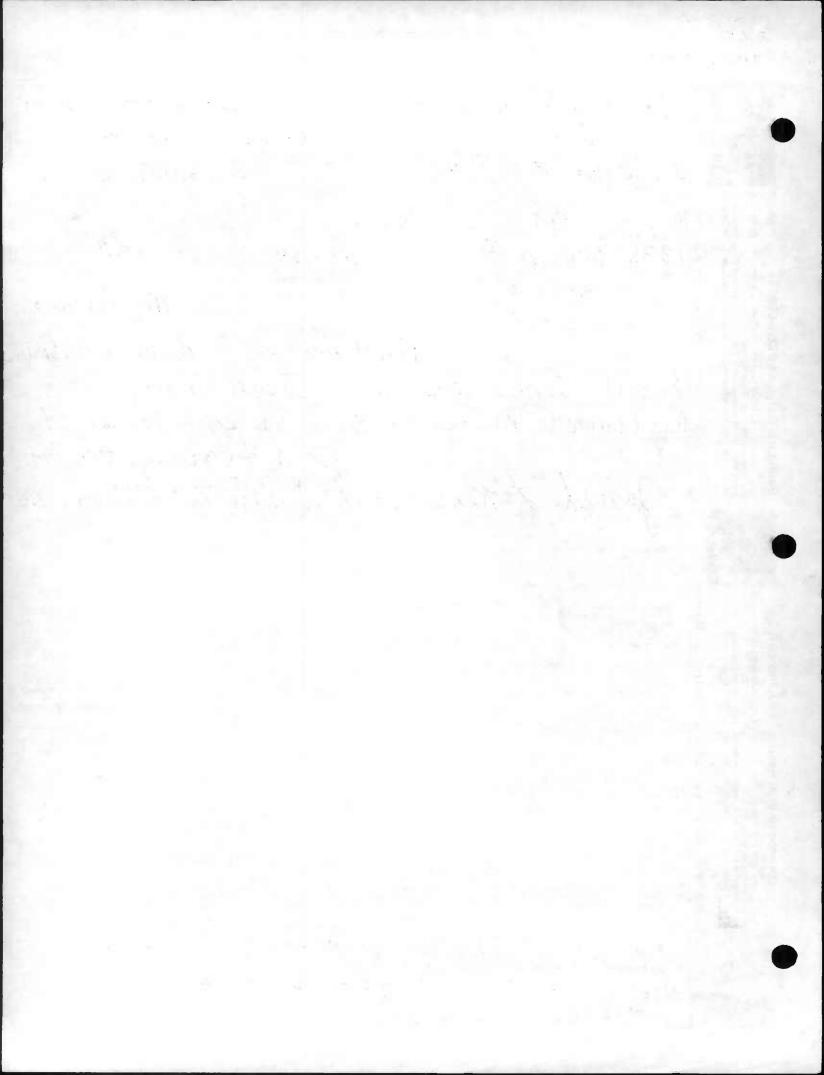
CARDO State of Maryland / Department of Health and Mental Hygiene 4/28/98 reb. Items: 23 part I,27,28a-f per MEO G-758 / Certificate of Death Reg. No. GREGORY RICARDO 1. Decedent's Neme (First, Middle, Last). 2. Dete of Deeth 3. Time of Deeth Month **Physician** Kobinson 18, 12:15 PM APRIL 1998 regor nicara /Medical 4b. City, Town, or Location of Death 4a Facility Name of not instifution, giva street and number) 4c. County of Death Examiner SOLAR CIRCLE PATTIMORE BALTIMORE If Under 24 Hrs. 5. Social Security Number if Undar 1 Yaar 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Deys Hours 219-70-0909 Usuel Residence of Decedent Yrs. Director the Merylend 10e State 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Magical Examiner must be nothled at 1 Yes 2 No Director laryland 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 38 d/L Funerai 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forcas? 1 D Yes 2 □ No If Yes, Give Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Meritel Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer nent of Health and Mentel Hygiene. Int: if Item 27 ie merked other than "natural", or ite 1 Never Married 2 Merried 1 Yes 2 No Maryland 21215-0020 Specify: by 3 ☐ Widowed 4 ☐ Divorced 1110 Hmericar Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) CP Hender 0 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 19b. Mailing Address (Street end Number or Rural Route Number, informent's Name/Reletionship (Type, Print) City or Town Stete, Zip Code) (wite) son Tabin other t Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetery or other) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cramation 3 F 4 Donetlon 5 Other (Specify) 3 Ramoval from State 6 permit. Pege Department of important: If any injury or once. ores 22. Name end Address of Facility us of Funeral Service Doensee Home Joseph Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirer tentral trail tree. List only one cause on each line. Ave Md. 21216 Balto. Approximate intervel Between Onsat end Deeth respiretory errest, **Physician** /Medical Immediate Cause (Final NARCOTIC AND ALCOHOL INTOXICATION disaese or condition rasulting in daath) Examiner Due to (or es e consequence of): Examiner hysician and the buriel-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. ettending physician certificate be Physician/Medical Due to (or es e consequence of): 98 980 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 월 Unknown à 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Completed complation of cause of death? page 2 s hes 1 Yes 2 No 1 Yes 2□ No certificate! Physician: 25. Wes case referred to medical examinar?
1 △ Xes 2 □ No Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) IN AUTO To this 28a. Date of Injury (Month, Dey Year) luneral 28b. Time of 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury et Work? After t Certification: Α. ision Affending fourniery 5 Pending investigation 1 Naturai death. 1 ☐ Yes 2 No Unknown found 4/18/98 s effer death 2 Accident 10:10 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 | Homicide Hospital or Unknown Unknown 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

(Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medical (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E APRIL 19, 1998 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Radentz Stephen APR 2 1 19 32 Ragistrar's Signeture

ta Davidson

1998

State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month LeRoy Gallant 15,1998 8:30 P.M. Rosenstock April /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** frederick memorial hospital FREDERICK FREDERICK | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | OCT 29, 1920 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) Birthplece (Steta or Foreign Country) **Funeral** 1□**M** 2□ F Yrs. 216-14-7907 Director MARYLAND Usual Rasidance of Decedent death with the Marylend 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2□No Director FREDERICK FREDERICK MARYLAND 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 110 BURGESS HILL WAY, APT. 218 21701 USA 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Ner 1 X Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Merried WHITE 1 ☐ Yes 2 💆 No Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) MERCHANT MEN'S CLOTHING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ROSENSTOCK HARRY LENA GALLANT 19e. Informent's Neme/Retationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) FREDERICK, MD 21701 101 W. 3RD ST. HARRY ROSENSTOCK (SON) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Spacify) any fnjury or 4/19/98 BALTIMORE HEBREW REISTERSTOWN, MD 22 Note and Address of Encility BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 tease, or confidentions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, une. List only one ceuse on each line. Onset and Daath Physician /Medicai Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Examiner SASTRO INTESTINAL bunal-trensit Sequentially list conditions, if any, leading to immediete cause. Enter Undarlying Ceuse (Diseese or Injury that initieted events resulting In daath) Last Due to (or es e consequance of) Records, P.O. Box 68760, physician 8/TIC ULCER Physiclan/Medicai the Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peed (ARDIOMYO IATINY hes certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: efter death. Director: After this certifica 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 2 ER/OutpetienI 3 DOA funeral 27. Mannar of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. Medical 29b. Signeture and titla of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 4. D. FREDERICK MEMBRIAL 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) M.D. 6. 753 St. FREDERICA HO 21701 GEORCE

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Dey, Yeer)

32. Registrer's Signeture

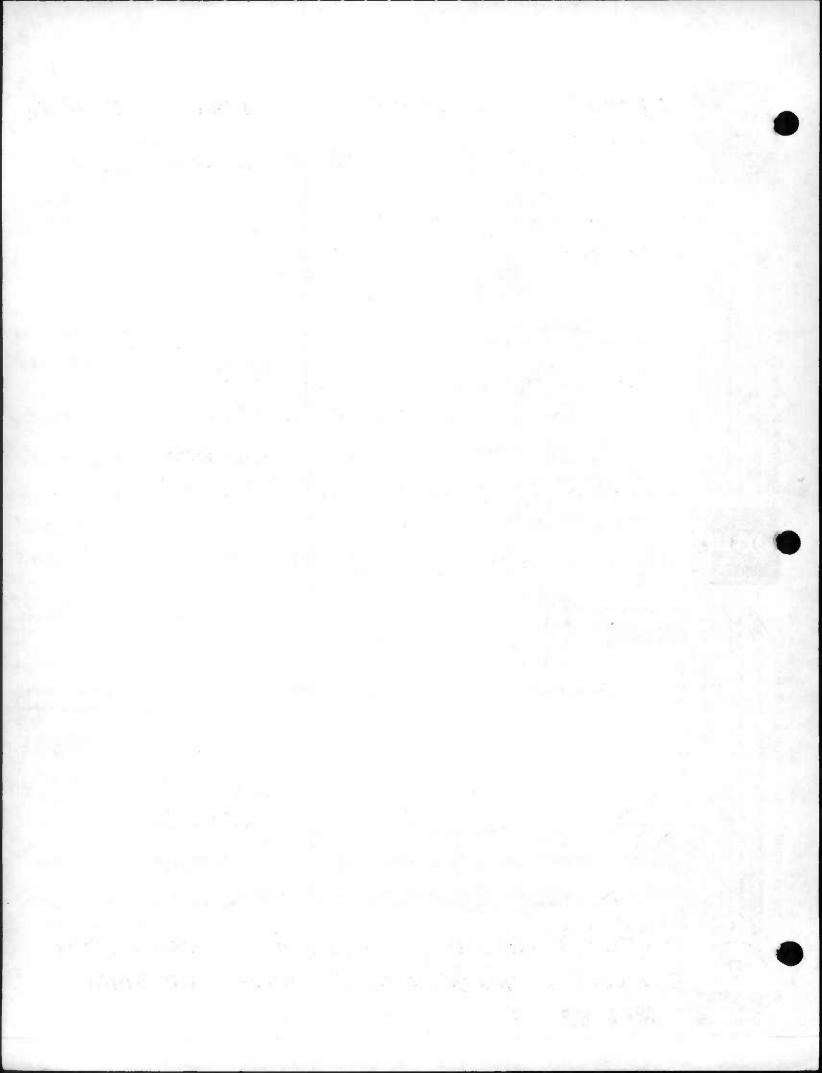
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

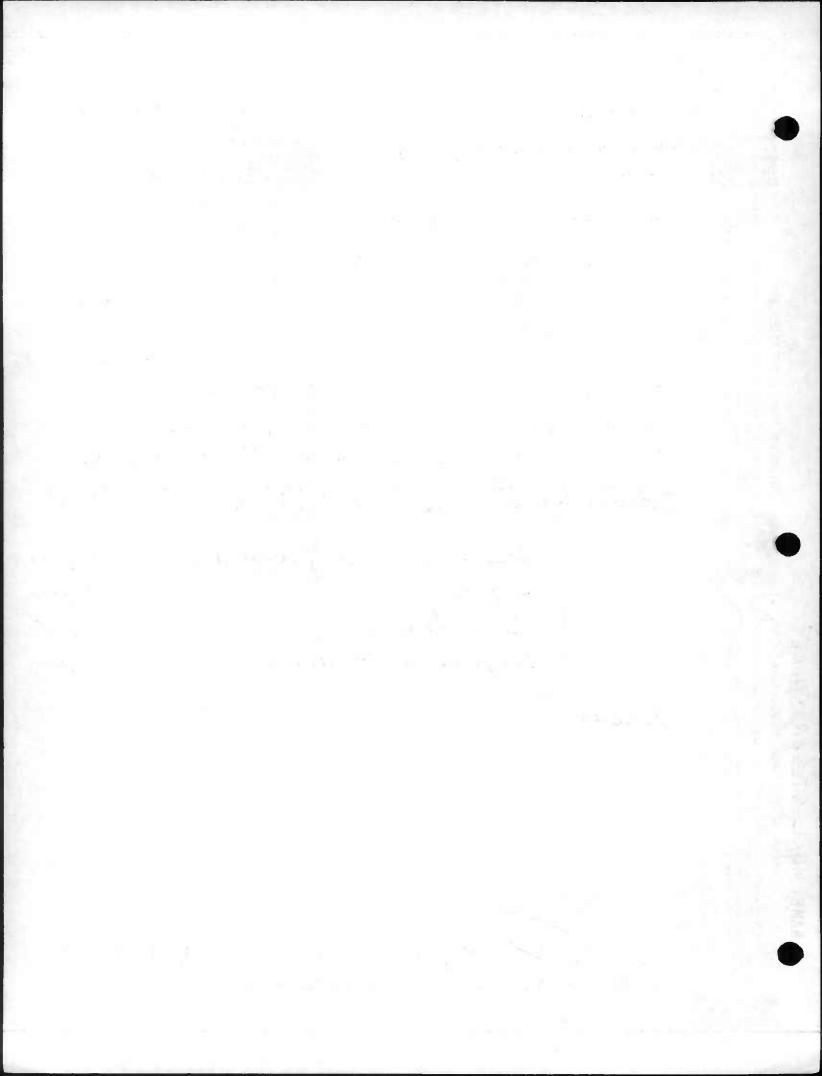
Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** PRIL 20 KEDPATH RTHUR /Medical 4e. Fecllity Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 336 Lynwood Drive Severna Park Anne Arundel H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. MAR 15, 1931 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) New York **Funeral** 157 M 2□ F 074-24-1359 67 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental tygene. Important: if them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic avant. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Anne Arundel Severna Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 336 Lynwood Drive 21146 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give A Baltimore, Maryland 21215-0020 1 Yes 2 No White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mechanical Design Elementery/Secondary (0-12) College (1-4or 5+) Consulting Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be Hugh Smith Redpath Lois Dorothy Tisdel 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet T. Redpath/wife 336 Lynwood Dr. Severna Park, MD 21146 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 4/20/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses Cremation Society of Maryland, Inc. F. McDona 299 Frederick Rd. Baltimore, MD 21228 McDonald Dawn 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) METASTATIC RECTAL CANCER Examiner Due to (or es e consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate to accused Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) signed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably To Unknown by been si Completed 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? page 2 s certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this Director: After this d in by the funeral Medical Certification: 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) after 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29e. Certifier 29b. Signeture and title of certifiers 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) ANNAP. MD 21401 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture State Julia Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 9

				Certificate d	or Death			Reg. No.	
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Registrar	APR 2 11	338	and investigation	-National					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** 1998 3:06 A.M Frederick Albert Schumm ADRI /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner FRANKIN 5. Social Security Number Square Center | Baltimore Rosedale Hospital 8. Date of Birth Month, Day, Year, NOV. 13, 1913 If Under 24 Hrs. 7. Age (Ih yrs. last birthday) Birthplaca (State or Foreign Country) ial Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min 218-10-2542 84 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Maryland Baltimore Director Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 4311 Piney Park Road 21128 U.S.A. Herns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No H Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: natural, or White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Collaga (1-4or 5+) Elamantary/Secondary (0-12) Pharmacy Pharmacist 18. Mothar's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) should be and Mental H. Schumm Barbara Duban marked Louis 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ä Pages 1 and 2 Anastasia A. Schumm 4311 Piney Park Rd., Perry Hall, MD Nom 27 (wife) 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) Date 20c. Locetion - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 4/18/98 Green Mount Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensea Buin a Willen 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical neumonia Examiner Due to (or as a consaquence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and attending physician Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. the 1 Yes 2 No 3 Probably 4 Unknown hronic Obstructive Pulmonary Disease PV Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed? Completed Renal Insufficiency, Cardiomy ope 1 □ Yas 2 No 1 Yas 20 No certificate 10 betes Attending Physician: 25. Was casa rafarrad to madical axaminer? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1. Inpatient 2 ER/Outpatient 3 DOA this in 24 hours after deau. In 24 hours after deau. In 24 hours after the funeral in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Daath 28h Time of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) Withful 2 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) -29c, License number

30. Name and addrass of person who complated ceuse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 2

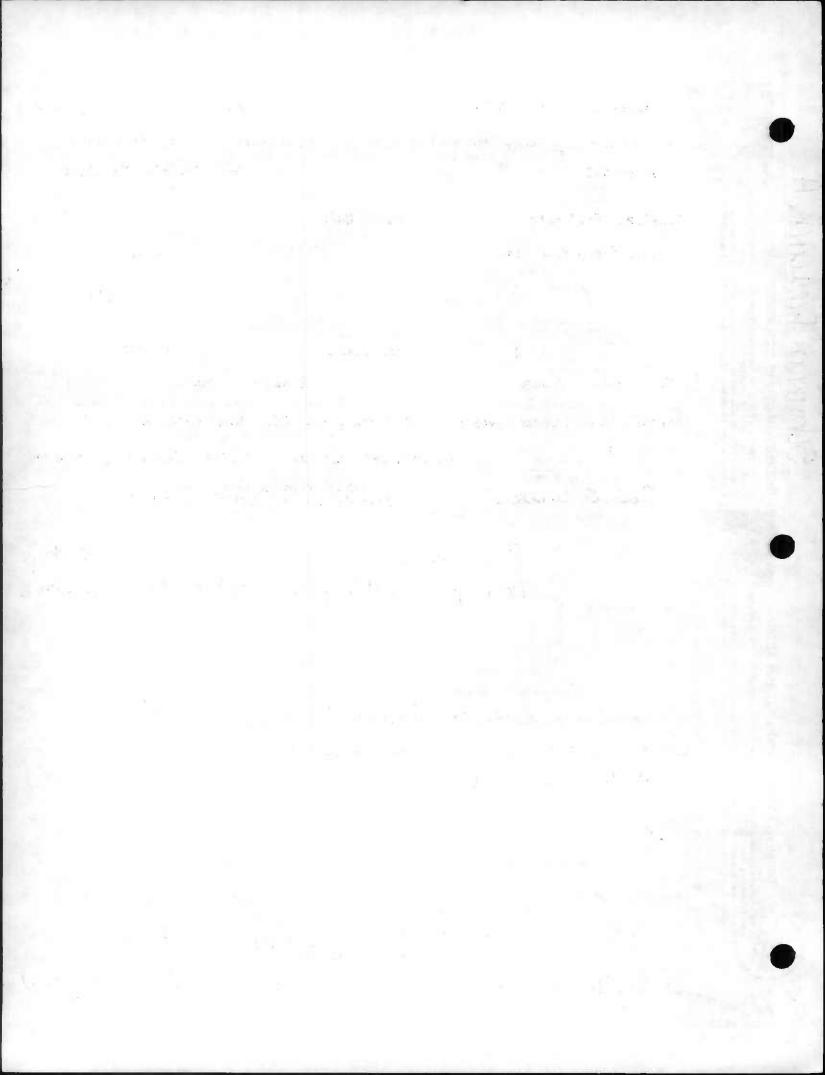
Shivananda 9000 Franklin

32. Registrar's Signature

Silia Davidsor

ware Drive Baltimore

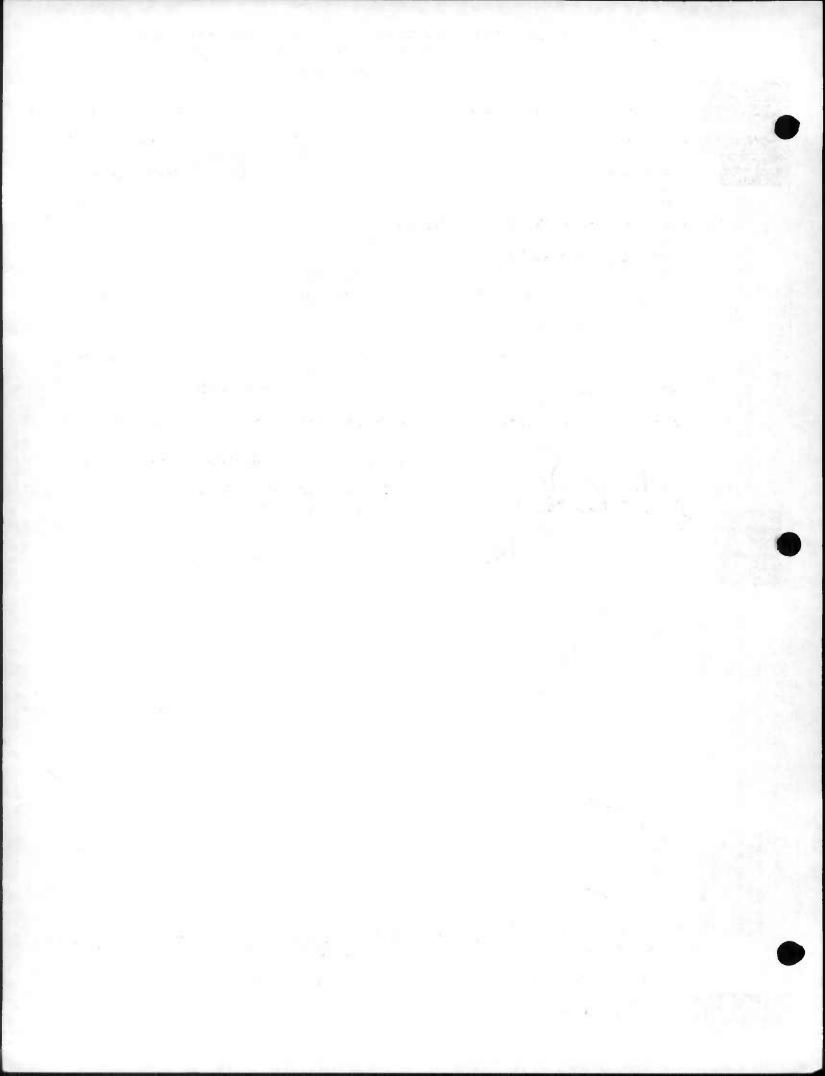
State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** MARIE SALAMON 12:10A14 98 20 /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince Geroge Golden Oaks Nursing Home Laurel 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 26, 19 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** 1 M 25 F 87 Yrs. Director 061-07-8190 1910 Hungary Usuel Residence of Decedent with the Marylend 10a State 10b County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Prince George Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8708 Cryatal Rock Lane 20708 USA death Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Marrled Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Manufacturing 8 Ø Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Martin Salamon Theresa Resch 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 8708 Crystal Rock Lane, Laurel, Maryland 20708 Nancy Z. Matthews/Niece 20b. Plece of Disposition (Name of cemetery, cremetory or other placa) Method of Disposition
1 Disposition 3 Premovel from State 20c. Location - City or Town, Stete 4 Dong on 5 Other (Speg St. Raymond Cemetery 4/23/98 Bronx, New York Funeral Service Lie 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laure1, MD 207.07

Approximately a spring Road, Laure1, MD 207.07 Enter the Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Physician/Medical Examiner physician end s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760 Due to (or es e consequenca of): 98 P.O. 1 ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown signed t Records, þ cate has been sig pege 2 should b 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital dling Physician: director, Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 2 erel 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Process 3 ☐ Suicide 8 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 \(\text{Homicide} \) within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) end menner steted. 29a. Certifier Medicai \$ 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) MAN DYSEN RD , SUITE 130, LAUREL, MD 20707 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State produce gandale Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Yeer **Physician** 19, 1998 April 7:50 PM John H. Sanders /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner 10 1/2 Old Court Road Pikesville Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** Min. Days 1 ☑ M 2 ☐ F Months Hours Director 93 Nov 15, 1904 215-07-4885 Maryland Usual Residence of Deceden the Marylend 10d. tnside City Limits 10a. Stata 10b. County 10c. City. Town or Location show 7 is marked other than "naturel", or flams 23a or 28a-f shov traumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 1/2 Old Court Rd. 21208 USA deeth Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after arment of Health end Mental Hygiena. ortant: If item 27 is marked other than "naturel", or the injury or other traumatic event, the Modital Engine 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 years Carpenter Foreman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Alice M. O'Connor Jacob A. Sanders 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 1/2 Old Court Rd. 21208 William Sanders (Brother) Pikesville, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department of important: If any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4-22-98 Pikesville, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 231. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Physiclan . ADENOCARCINOMO, UNKNOWN PRIMARY /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner CACHEXIA sician end burial-transit Sequentielly list conditions, if any, leeding to Immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medicai Due to (or as e consequence of): 88 nse 0 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings available prior to Completed 24e. Was an eutopsy performad? completion of cause of death? page 2 s 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Affending Physician: funeral diractor. 25. Was cese referred to medicel examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Yeer) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending r death. 1 ☐ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide ortal br 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Madical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. the To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 1. Date Glad (Month, Day, Year)

PANE and address

32. Registrer's Signature

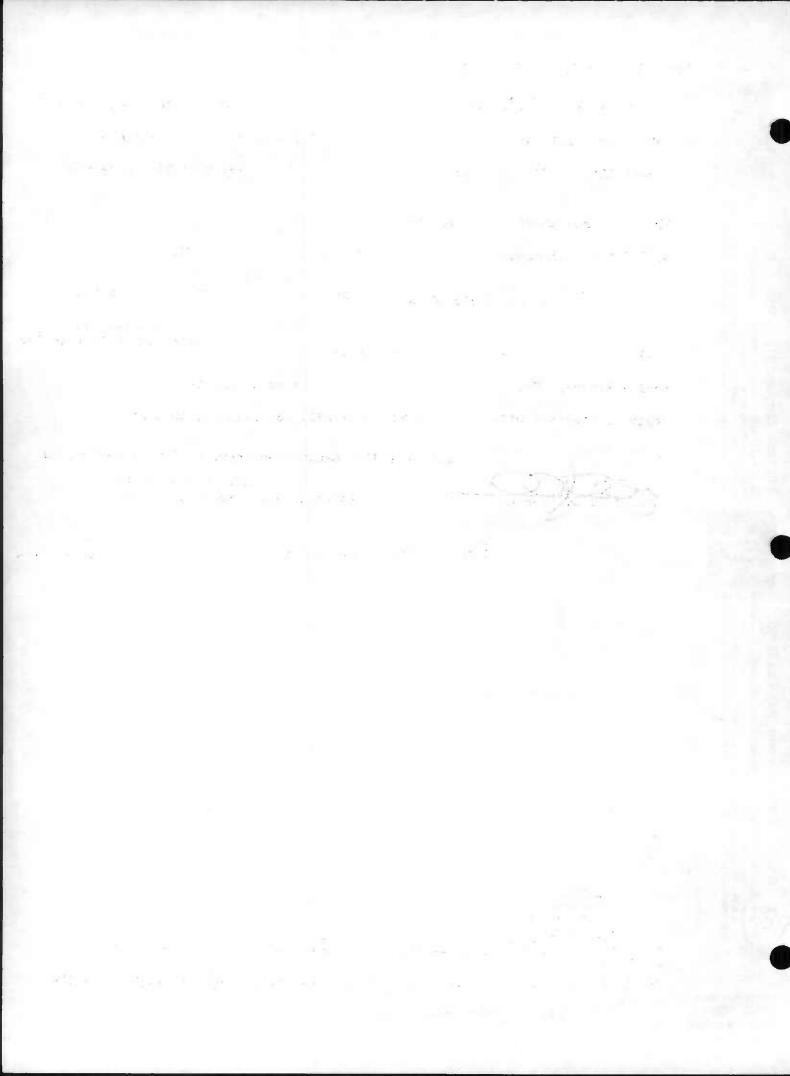
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Item: 16b per F.H. G-758 4/21/98 re Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 03:45 tecker ouis /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Baldwin, MD 4902 Horse Hill Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1936 9. Birthpleca (Stete or Foreign 5 Social Security Number 7. Age (In yrs. lest birthday) **Funeral** XX M 2□ F Months Days Hours Min Mary land Yrs. May 212-34-3840 61 Director Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or fems 23a or 28a-f ebov traumstic event, the Medical Experience must be notified at 1 Yes 2 No Director Baltimore Baldwin. MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23a or 2 any injury or other traumatic event, the Medical Exercises or 2 and 24 and 25 and 2 and 25 and USA 21013 4902 Horse Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Wes Decedent Ever In U,S. Armed Forces? 11. Maritel Stetus Bleck, White, etc. 1 XYes 2 No
If Yes, Give 1960-1964 1 ☐ Never Married 253 Merried White Baitimore, Maryland 21215-0020 1 Yes 2000 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Conditioning Air Gondishing/Heating Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Margaret Morris Louis Stecker, Sr. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4902 Horse Hill Rd, Baldwin, MD 21013 19a. Informant's Name/Reletionship (Type, Print) Peggy A. Stecker/ Wife 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other Specify Dulaney Vallay Mem. Gardens Apr. 20, 1998 Timonium, MD 22, Name end Address of Fecility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 lagle 23a. PertT. Enter the disease, or real clicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete tntervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Prostate (month cancer Examiner Due to (or es e consequence of) Examiner requires that the deeth certificate be executed physician and the burief-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequenca of): 98 USB signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en autopsy Completed page 2 s has 1 Yes 2 No 1 TYes 2 No certificate or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 10 1 Yes 2 No After this funeral 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Naturel 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner steted. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 36131 - MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 7600 Osler Drive, Towson, MD 21204 Brave Suite 203

State Registrar

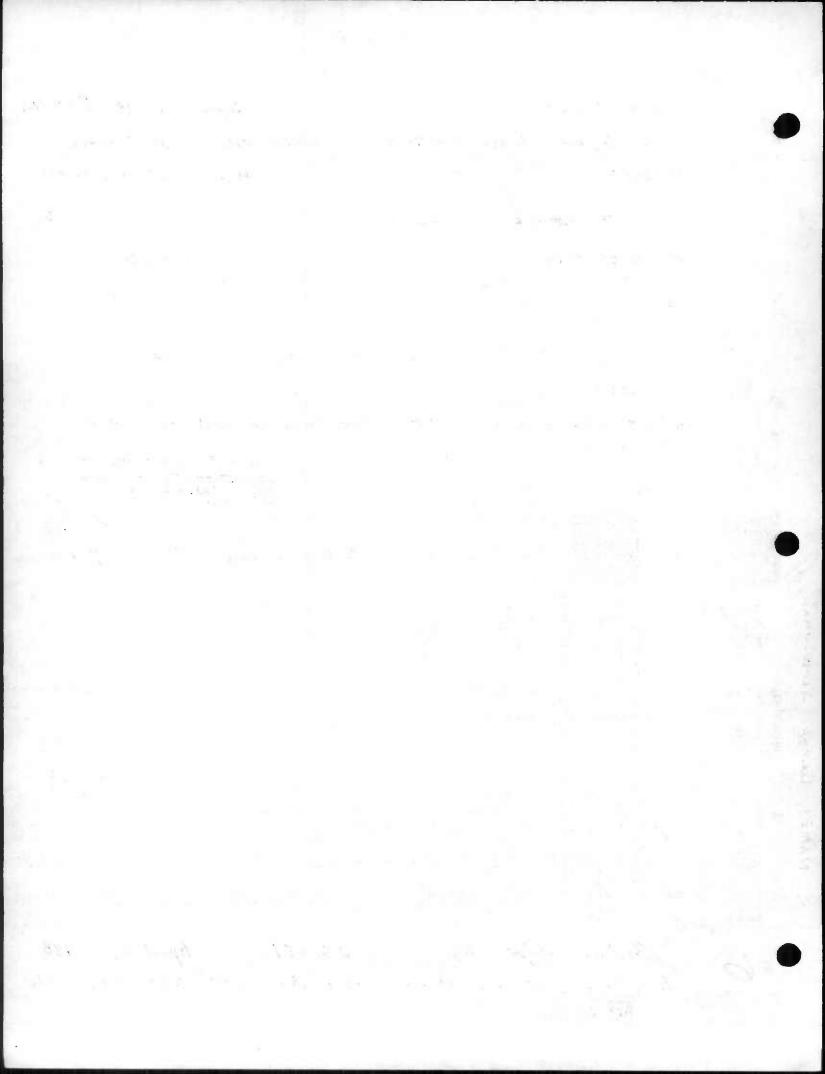
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/Medi		Beryl K. Simo	olunas						Apri	1	98	5.00 AN		
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Simolonas

NAME



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Deeth **Physician** APRIL JAE SHAFFER 18,1998 JOANNE 1310 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE Hours Min. SEPT. 27,1958 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ xF 39 Yrs. Director 213-72-3232 MARYLAND Usuel Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MARYLAND BALTIMORE OWINGS MILLS Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 9218 LEIGH CHOICE CT. Funerai filed within 72 hours efter deeth 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. important: if item 27 is marked other than any injury or other transmission. Elementery/Secondary (0-12) College (1-4or 5+) BELL ATLANTIC 12 LEGAL CLERK TELEPHONE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be NERWIN 2 SHAFFER SHEILA SATOSSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. SHEILA SHAFFER (MOTHER) 9218 LEIGH CHOICE CT. OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH ISAAC ADATH ISRAEL 4-19-98 BALTO., MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligania 22. Name and Address of Facility Sol Levinson & Bros., Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heert failure. List only one cause on each uner 8900 Reisterstown Road Baltimore, MD 21208 Approximate Intervel Between Physician /Medical Immediate Ceuse (Final PHYLLDIDES CYSTOS ARCOMA 5 5 Ans disease or condition resulting in death) Examiner Due to (or es e consequença of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of) Physician/Medical The law requires that the death certificate Due to (or es e consequence of) Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? this certificete 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Year) Medicai Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation Netural death. 1 Yes 2 No 2 Accident Director: in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C completely filled the Hospitai Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 18, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. L.- SESAI MO. SKOI OLD COURT RD., N.W. HOSPITAL CTRA, RANDALLS TOWN
31. Date filed (Month, Day, Year) 32. Registrer's Signature MO 2(13) State white Davidson APR 21 1998 Registrar

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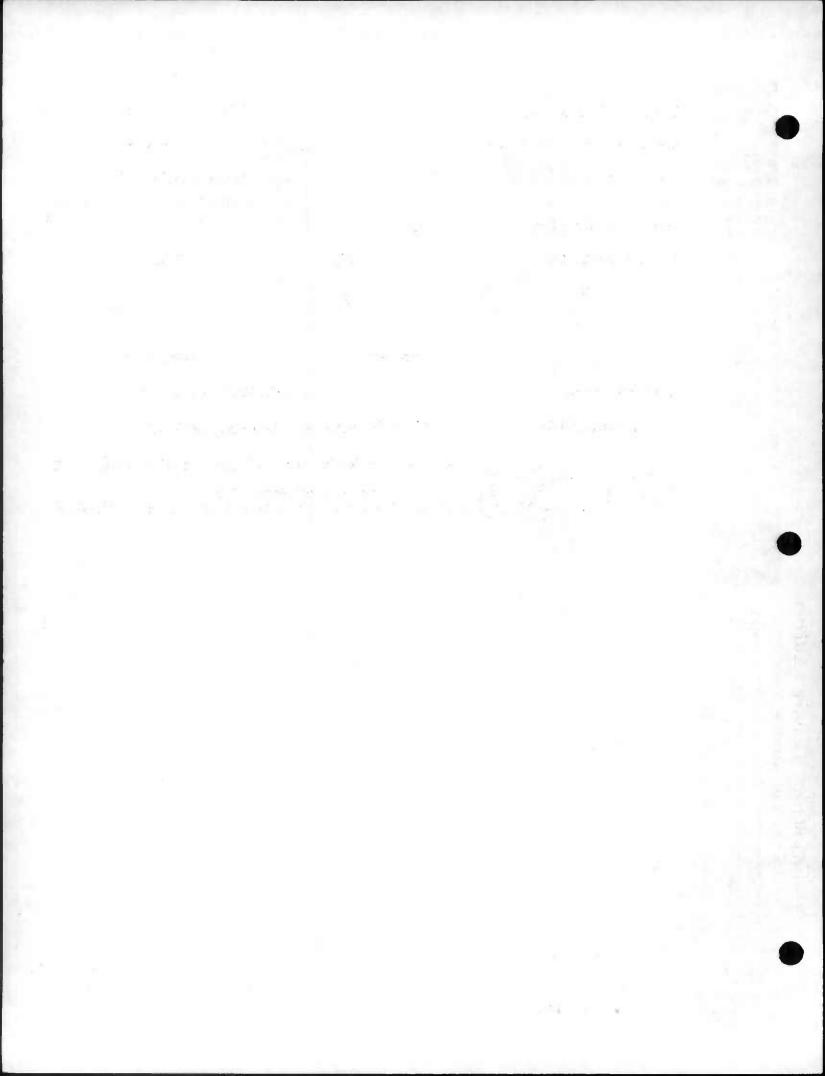
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State of Maryland / Department of Health and Mental Hygiene

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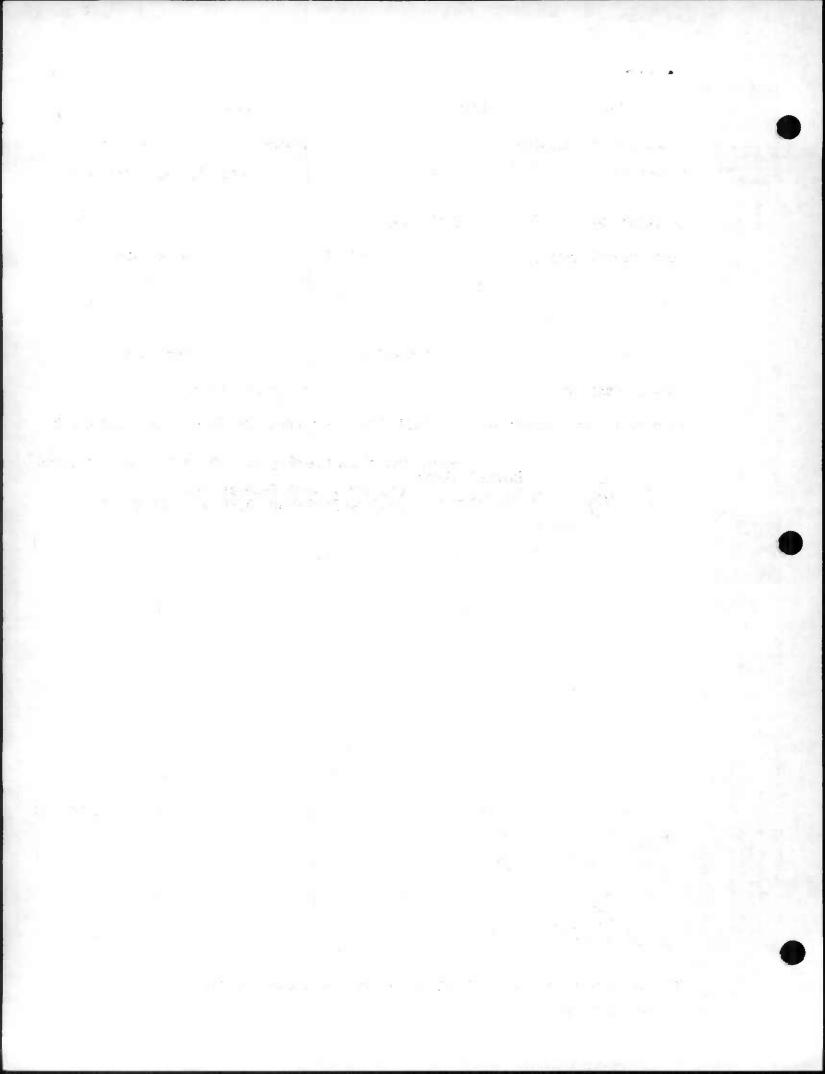


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea No. 9 8 | 259

			A 1 3			Certi	ficate of	Death		Reg. No.	1 1	591	
	Discort of		1. Decedent's Neme (First, Middle,	Last)					2. Dete of De	eth		3. Time of Deeth	
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L			Stella Maris H	ospice				Towson		Bal	timore	3	
	Funeral			6. Sex 7. Ag 1 □ M 2 🕱 F	e (In yrs. lest bi	N	f Under 1 Year fonths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De June 24	th by, Year)	9. Birthpled	ce (Stete or Foreign	
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	r 28g	Director	10e. Street end Number		Durci	T	10f. Zip Code			10g. Citizen of V	Whet Country	n	
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			23e. Part1. Enter the disease, or o	omplications that caused	fhe death. Do	not enter f	he mode of dyl	ng, such es cardiec	or respiretory e	ore, MD	21214	pproximete	
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89	The law requires that the death certificate be- ite has been signed by the ettending physical page 2 should be detached for use as the burn		resulting in deeth) Lest										
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i			1				9	13202		4 %	e · 98	ş-	
,	6	-	30. Neme end eddress of person wi	no completed cause of de	eeth (Item 23a)	(Type, Prir	nt)						
			DR. EDDIE NAKHU		LANEY V	ALLEY	RD.	TIMONIUM,	MD 210	93			
	Sta	te	31. Dete filed (Month, Dev. Year) APR 21 1990	37. Registra	s Signeture	anda 00		,					
	Registr	ar	WILL OF 1939) A Well	and the fact and the	·							



J.E.T 98-2174-005 JOHN TUNNARD

STEVENS

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygi

Certificate of Death

ene g. No.	0	0	- 1	0	1-00	0	1
g. No.	3	0		2	0	7	6

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

1605 Pinnacle Rd.

5. Social Security Number

402-01-5539

Stevens

2. Dete of Deeth Dey 3. Time of Deeth

Funeral

with the Meryland r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Heelih and Mantel Hygiane. Important: If item 27 is marked other than "naturel", or items 23a any highry or other traumatic event, the Medical Examinet must and bota. 4e Fecility Neme (If not institution, give street end number)

4b. City, Town, or Location of Deeth

19 1998 4c. County of Deeth

3:11A.M

10d. Inside City Limits

1 Tyes 2KINo

Director

Usuel Residence of Decedent Directo Funeral à Completed

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Deys 1⊠M 2□F

88

Hours

8. Date of Birth (Month, Dey, Year) May 12 1909

BALTIMORE Birthplece (State or Foreign Country) Nebraska

10a. State MD. 10e. Street end Number

Baltimore 1605 Pinnacle Rd.

Towson

Yrs.

10c. City, Town or Location

10f. Zip Code 21204 10g. Citizen of Whet Country?

USA

11. Meritel Status

1 Never Married 2 Married

10b. County

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:

 Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Yes 2 No Specify:

14. Rece - American Indien. Bleck, White, etc.

3 ☑ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director Of Training

16b. Kind of Business/Industry

Federal Government

17. Fether's Neme (First, Middle, Last)

Elementery/Secondary (0-12)

Arthur

Stevens

Carrie

18. Mother's Neme (First, Middle, Maiden Sumeme)

Storey

Approximete Intervei Between Onset and Deeth

White

George

19e. Informent's Neme/Reletionship (Type, Print)

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

21. Signeture of Funerel Service License

Lillian Blanche Stevens/Sister

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

800 Southerly Rd. Towson, MD. 21286

20c. Location - City or Town, Stete

Towson, MD.

20e. Method of Disposition

1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

Hilltop Service Co.

4-21-98

22. Name and Address of Fecility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Pert1. Enter the disease or complicatione that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

26. Piece of Death (Check only one)

Physician /Medical Examiner

signed by the e

peen

certificate has t irector, page 2 s

this funeral

After t or Attending F

n 24 hours etter com-the Funeral Director: Afti-lataly filled in by the fu

completely Within 2. To the

by

Completed

Be

7

Certification:

Division of Vital Records,

Physician:

Immediate Ceuse (Finel disease or condition resulting in death) Physician/Medical Examiner ettending physician end for use es the buriel-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events The law requires thet the death certificate be resulting in death) Lest

Contact Gunshot Wound of Head Due to (or es e consequence of)

Due to (or es e consequence of):

Due to (or es e consequença of)

Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

pontial 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐ No

25. Wes cese referred to medicel examiner? ₩Yes 2 No

28e. Dete of Injury (Months Dey Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 0-311 AM 4-19-98

28c. Injury et Work? 1 Yes 2 ₽No

Other: 4 Nursing Home XXResidenca 6 Other (Specify) 28d. Describe how injury occurred self-inflicted gunshet wound

APRIL 19

27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

4 Homicide

28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 65 Pinna cla Road Baltimore, Md home Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner stated.

29b. Signeture angititle of certifie

hute no

O.C.M.E

29c. License number

29d. Date signed (Month, Dev. Yeer)

1998

30. Name end eddress of person and completed ceuse of deeth (Item 23e) (Type, Print) hute, no

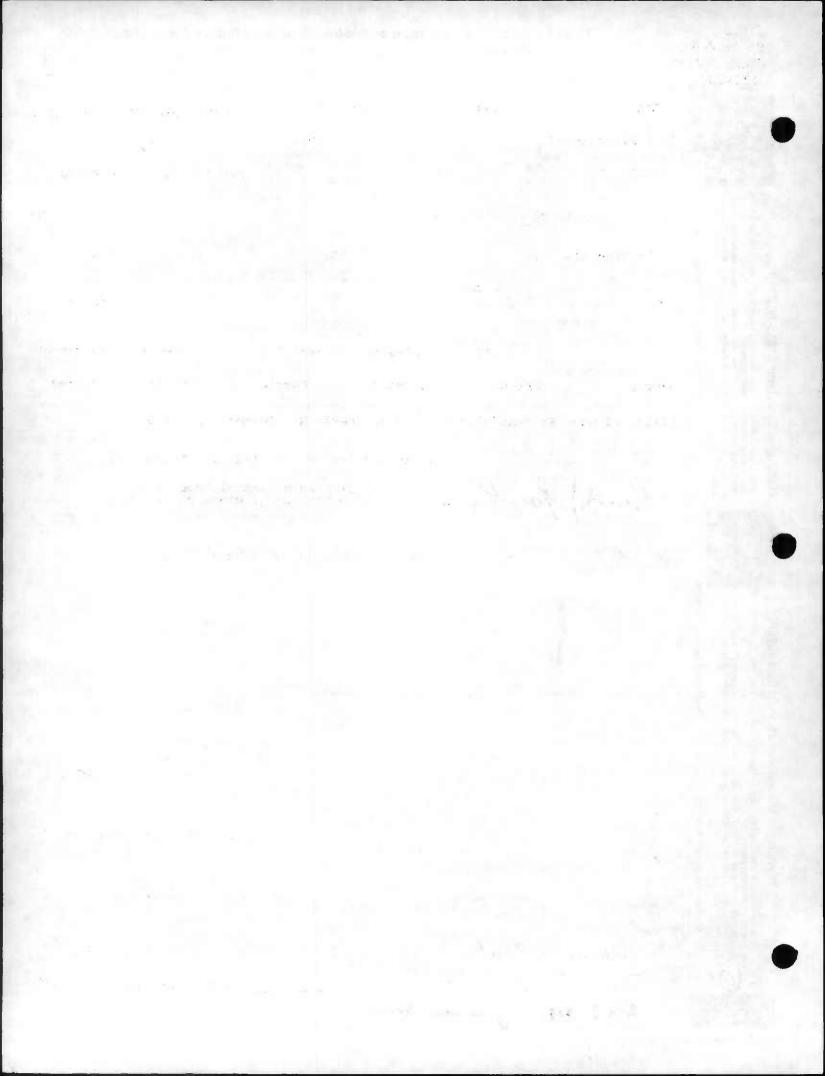
111 Penn Street, Baltimore, Maryland 21201

Registrar

5 Pending

6 Could not be determined

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 1000 Month S April 4b. City, Town, or Location of Deeth 19196 CVIN 14 1998 Am. 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth JOSEPH RITCHIE HOSPICE BALTIMORE N/A 7. Age (In yrs. lest birthday) If Under 1 Year 5 Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplece (State or Foreign Months Deys **№** M 2□ F 11/07/1963 219-86-2350 34 Yrs. Maryland Usuel Residence of Decadent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore 1 DXYes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1630 Bentalou Street 21216 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Unknown Unknown 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Leon Speights Hattie Louise Speights 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lisa Speights 1223 Bayard Street, Balto., MD 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery4/21/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth fmmediete Ceuse (Finel 50015 diseese or condition resulting in death) Due to (or es e consequence of): meumo / horav Musing Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown MASUM 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Dete of Injury 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work?

P.O. Box 6876 The lew requires that the deeth certificate ate hes been signed page 2 should be det Records, certificate of Vital Hospital or Attending Physician: director, After this illed in by the funeral Division 24 hours efter death.

Physician/Medical Examiner þ Be Completed To Certification:

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Director

Completed by Funeral

Be

the Marylend

with

death

filed within 72 hours efter

th end Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical

nt of Health e if Item 27 is or other tra

Physician /Medical

Examiner

Pages 1 end 2 should be family and Mental

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enfer Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - Af home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edicai 29a. Certifier

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

Hospice Bacto mo 21201 ATHARINE 31. Date filed (Month, Day, Year)

State Registrar

completely

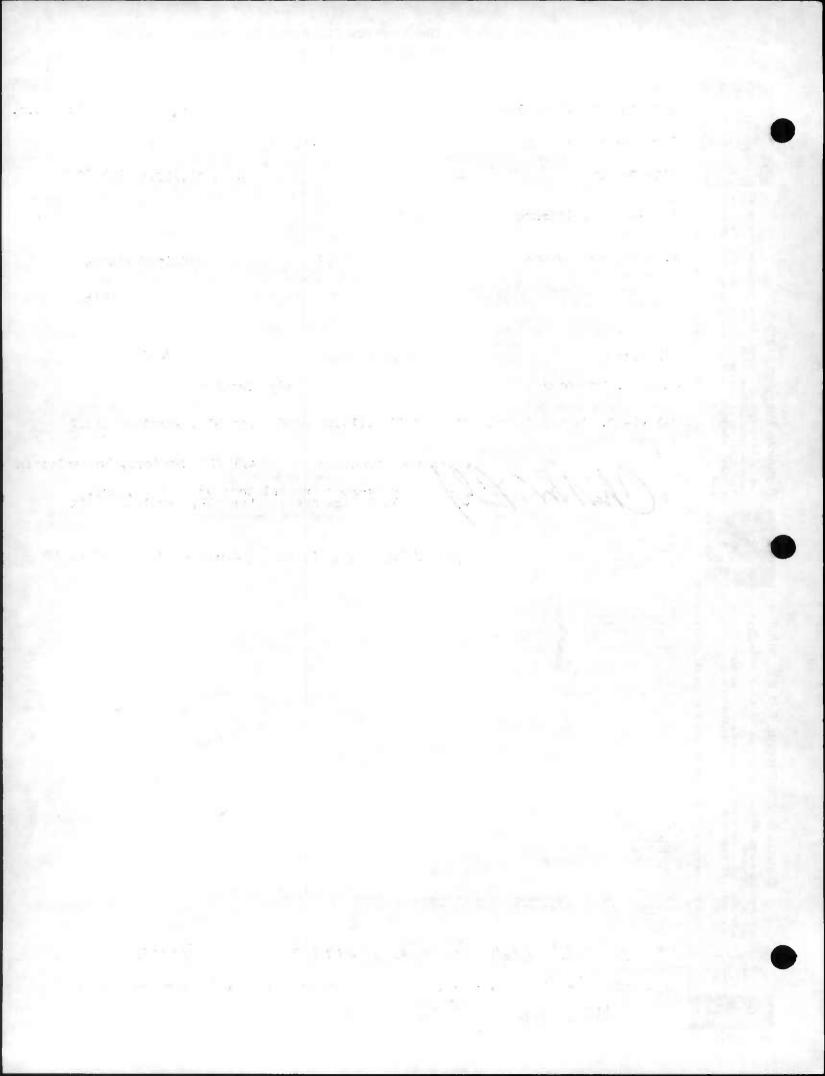
within 2 To the I ş

> 32. Registrer's Sign APR 21 1998 This Davids

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last)						Reg. No. 2. Date of Deeth Month Dev Ye			3. Time of Deeth			
Loretta Jean Shan						Month	Dey	Yeer	7.50			
An English Name (Mast institution size				4b	City Town, o	April or Location of Deat	17, 1998		7:50 a.m.			
							10.000.11					
1706 Pin Oak Aven		n con for at friether	foul If Linder		Dundalk If Under 24 H			ltimor				
102 22 3230	M 2 F 69	n yrs. last birthd Yrs	Months		Hours M	n. (Month, Di	3, 1928	Country New	ce (State or Foreign /) York			
Usual Residence of Decedent	Tax	C. City. Town o	a Lanakian					404	Library Charles			
10a. Stete 10b. County Maryland Baltime		Dundal						100	I. Inside City Limits 1 ☐ Yes 2 ☑ No			
Maryland Baltime	1		10f. Zip	Code			10g. Citizen of N	Whet Country	y?			
1706 Pin Oak Aven												
	12. Was Decedent Eve	r in HS 1		1222	panic Origin?	(Specify Yes or No	United	States a - American	S			
11. Maritel Stetus	Armed Forces?	1110,3.	If Yes, spec	cify Cuban,	, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	Bleck, Whit					
	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2	2 No	Specify:		Specify	www. Whit	te			
3 Widowed 4 □ Divorced	Year or Dates:											
15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. De	ecedent's Usue Bive kind of wor fe. DO NOT us	el Occupati ork done du	ion I <i>ring most of</i> w	vorking	16b. Kind of B	usiness/Indus	stry			
Elementary/Secondery (0-12)	College (1-4or 5+)	`lit	fe. DO NOT us	se retired)								
11 years		Gou	rmet Ca				Food					
17. Fether's Name (First, Middle, Last)					18. Mother's Neme (First, Middle, Maiden Sumame)							
James M. Crawford					G1adys	Lash1ey						
19a. Informent's Neme/Reletionship (7)	vpe, Print)	19b. M	failing Address	s (Street an	nd Number or	Rural Route Numb	per, City or Town,	State, Zip C	code)			
Valerie J. Howard		822	7 Bulli	neck	Road	Dundall	. Marvla	nd 211	222			
20a. Method of Disposition		20b. Plece of Di	isposition (Nan	me of		Date	20c. Location					
1 € Burial 2 Cremation 3 □F	Removal from State	cemetery,	crematory or o	other placa))							
4 Donation 5 ☐ Other (Specify)	1	Fairvie	w Cemet	tery		4/19/98	Bedfor	d, Pen	nsylvania			
21. Signature of Juny at Service Licens	· / //	/	22. Name an									
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222												
23a. Pert I. Enter the diseese, or compl	lications that caused hi								Approximate			
shock, or heart failure. List only of	ne ceuse on each ine.											
			ontor the mod	te or dying,	, 30011 03 0414	iac or respiratory		lr C	ntervel Between Onset end Deeth			
disease or condition	G	2						C	ntervel Between Onset end Deeth			
disease or condition resulting in death)	e. Du	2	ic le	ung C				C	Onset end Deeth			
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Nathaniel 3 /Medical 4a. Facility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Baltimore Hospital DRCOUTS 7. Aga (In yrs. last birthday) if Under 1 Year | if Under 24 Hrs. 5. Sociel Sacurity Number 6. Sax 8. Data of Birth (Month, Day, Birthplaca (Stata or Foreign Country) **Funeral** 100M 2 F Months Deys Hours Min 215-76-3204 38 Yrs. Director Usual Rasidanca of Dacadant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or items 23a or 28s-f show ury or other traumstic event, in a Medical Examinal mass be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits NIA BALTIMORE 1 XYas 2 No Funeral Director MD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1901 N. FULTON AVE. 4.5. 21217 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No if Yas, Giva / Yaar or Dates: Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) Rece - Amaricen Indien, Black, Whita, etc. 11. Marital Status 1 Navar Married 2 Marriad 1 ☐ Yas 2 No Spacify. Be Completed by 3 Widowed 4 Divorced Specify: BLK 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) 115 LABOR -0-17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) COOPER WILLE ALICE BRVANT 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) COLE JUDITH 5517 GWYNN DALE BALTIO, M) 21201 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 12 Burial 2 Cremation 3 Ramovai from Stala Department of important: If any injury or DUNDALK, MD 4 ☐ Donation 5 ☐ Othar (Specify) HEART CEMT. 22. Name and Address of Facility E.L. PAIIIPS 21. Signatura of Funaral Sarvica Licansas 1721-27 N. MONROE S. BALTIR. MD 2,2,7 CFSYP eretha Decta 23a. Part1. Enter the disaesa, or complications that caused the death. Do not an artha mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death **Physiclan** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Due to (or es a consequança of): signed by the attending use art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco ues contribute to the cause of death? 1 ☐ Yes 2 ☐ No Probably 4 Unknown Completed by 24b. Wara autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was cesa rafarrad to medical 26. Placa of Daath (Check only ona) axaminar' Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas Medical Certification: To 27 Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 DaNatural

Hospital or Attending Physician: The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, filled in by the funeral director, page 2 should be detached for After this certificate has been Division death.

Baltimore, Maryland 21215-0020

5 Panding invastigation 2 Accidant 6 Could not be datarminad 4 Homicida

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata)

29a, Certifian

3 Sulcida

Cartifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and maintain as section.

E Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end litle of certifian

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29d. Data signad (Month, Day, Year)

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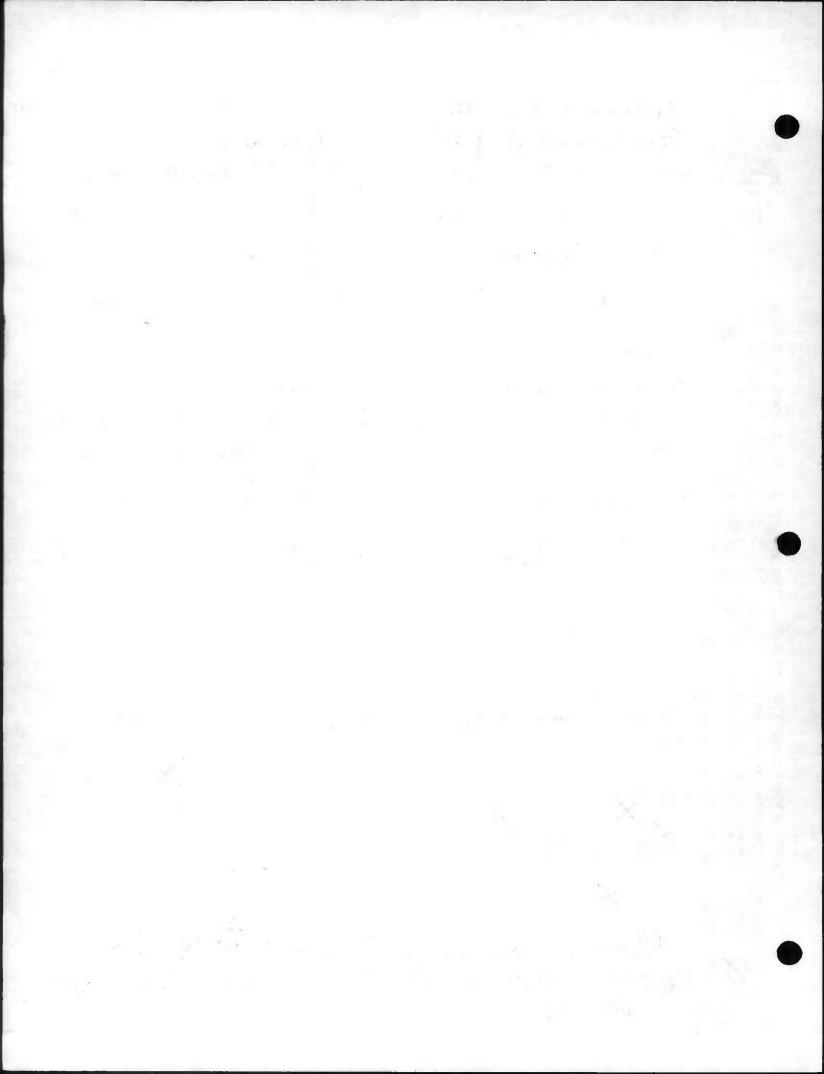
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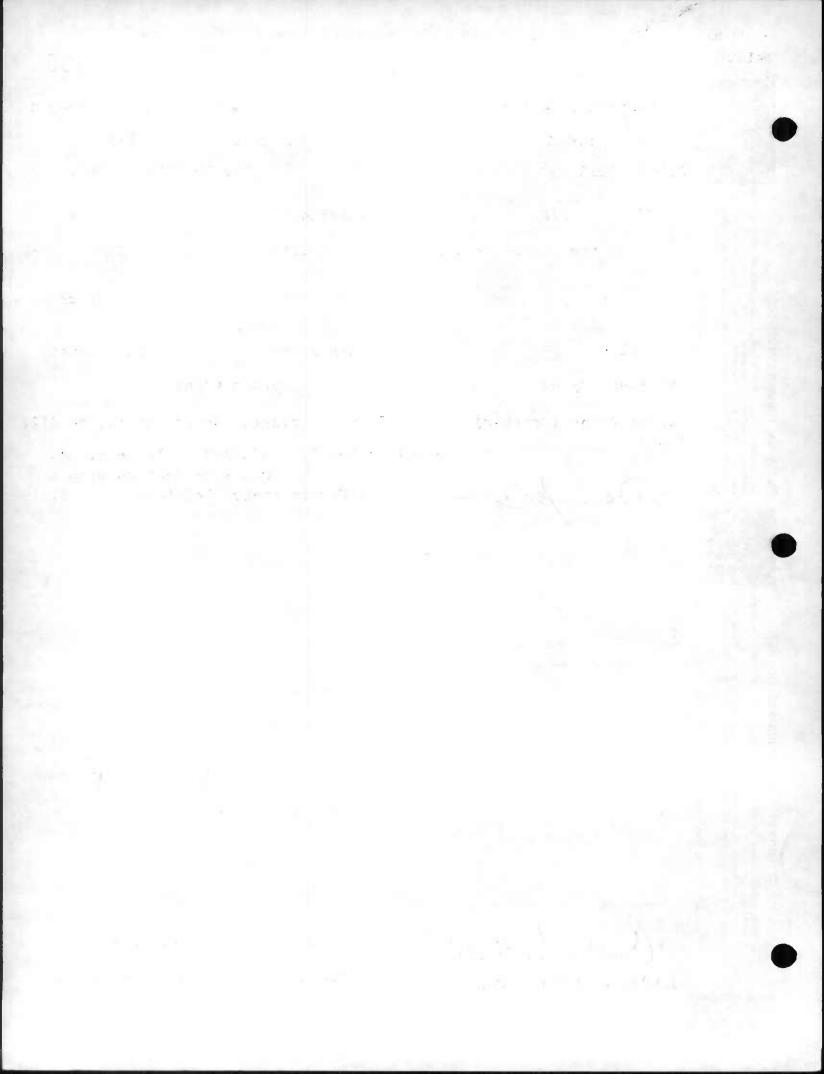
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	Exami		4a. Facility Name (If not institution, give VAMHCS FT • HOV		ISION			, Town, or Lo	cation of Deeth	4c. County BALT		?E		
	Funeral Director		5. Social Security Number 6. Security Number 2 1 6 - 0 1 - 4 6 4 0		(In yrs. last	birthday) If Under 1 Y		nder 24 Hrs.	8. Date of Birt Month, Day March		9. Birtho	lece (State or Foreig	'n	
	yland		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	own or Location					1	0d. Inside City Limits	S	
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	23ª or 3	Funeral Director	1743 Drexel Rd.			10f. Zip Co 2	1222			10g. Citizen of V USA	Vhet Cour	itry?		
020	urs efter des il', or flems	by Fune	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1. Yes 2 □ N If Yes, Give Yeer or Dates	0	13. Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	Cuben, Me	dcan, Puerto	ecify Yes or No- Rican, etc.)		k, White,			
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heath and Mentel Hygiene. Important: if kern 27 is marked other than "natural", or items 23a or 28a-f show any houry or other traumatic event, the Medical Event set must be notified at once.	Completed	15. Decedent's Edu (Specify only highest gred	cation	1(Sa. Decedent's Usuel O (Give kind of work d life. DO NOT use n	one during etired)	most of worki	ing	18b. Kind of Bu	·			
pul 5	be filed tel Hygi d other event, t	To Be Co	17. Father's Name (First, Middle, Last)	II/A		achine ope		lother's Name	(First, Middle,	Steel Meiden Surnam		ry		
aryla	Aaryla 2 should and Men is marks		Perfecto Tallon 19a. Informent's Neme/Relationship (T)	roe. Print)	1	9b. Meiling Address (Si		dith Po		r City or Town	State Zin	Code)		
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Baltlmore, Maryland	Pages 1 Iment of H tant: if ker jury or ott		20e. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Plece ceme Oa.k.]	of Disposition (Name of tery, cremetory or other awn Cemete	ry			Baltimo				
Bal	Dapar Dapar Impor any In	4	In live	1. Signature of Funeral Service Lidensee 22. Neme and Address of Feolity Della Noce & Sons Funeral Home 322 S. High St. Balto. 21202 Md.										
	Physician)	art f. Enter the disease, or comp shock, or heart feiture. List only o	ications thet caused ne ceuse on eech line	the death. D	o not enter the mode of	dying, such	n es cardiec d	or respiratory ar	rest,		Approximete Interval Between Onset end Death		
	/Medical Examiner		Immediate Cause (Fine) disease or condition resulting In death)	θ		TED CONGE	STIV	E HEA	RT FAI	LURE		Days		
	D #	iner	Due to (or es e consequence of): ARTERIOSCLEROTIC HEART DISEASE											
ó	execute end ni-trans	Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury c.											
κ 68760,	artificate ing physicia e es the bu	Medical	Cause Disease or injury that initieted events resulting in death) Lest Due to (or es e consequenca of):											
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l Rec	The law ate hes page 2 s	Completed	KNEE AMPUTATION	J					101	es 2000		death?]Yes 2□No		
Vita	Physician: The ribin certificate and director, page	Be	25. Wes case referred to medical exeminer?	lospitel: 3232			Other		(Check only o				_	
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State of Maryland / Department of Health and Mental Hygiene

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	Examir		4a. Fecility Neme (If not insti	ution, give	street end num	ber)				4b. City, Tow	m, or Loc	cation of Deeth	4c. County	of Deeth		
			Stella Maris	Hosp	ice					Timon:	ium		Bal	Ltimo	re	
	Funeral Director		5. Sociel Security Number 111-07-0332 Usuel Residence of Deceder		ex 7 ⊠M 2□ F	. Age (In yrs	. lest birthday) Yrs.	If Und Month	der 1 Year ns Days		4 Hrs. Min.	8. Dete of Birth (Month, Dey Jan. 1,	Year) 1919	9. Birthp Cour	olece (Stentry)	•Y •
	show	or	10a. Stete 10b. Co			10c. C	ity, Town or Lo	ocation						1		e City Limits
	the Mary	Director	Md. Bo	altim	ore	1	Towson		71-0-1-				0.00	***		CO LEGINO
	23a or		5 Intervale	Ct.				101.	Zip Code 212	86			log. Citizen of N		ntry?	
Maryland 21215-0020	72 hours after death with the Maryland natural", or items 23a or 28a-1 show dical Exa iner i wat be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ X 3 □ Widowed 4 □ Divo		12. Wes Decad Armed Ford 1 X Yes 2 If Yes, Give Yeer or Dat	es?				Hispanic Orlg en, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ck, White,	etc.	1,
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ary	short and A ma		19a. Informent's Name/Rela	ionship (7	ype, Print)			ng Addre	ess (Stree	-	or Rura	Route Number	r, City or Town,			
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altimore,	es 1 and 2 should be fi of Health and Mental H i Itam 27 is marked oth r other traumatic ever		20e. Method of Disposition				Plece of Dispo	osition (f	Verne of	ece)	T	Dete	20c. Location -	City or To	own, Stete	9
Ĕ	permit. Pages Department of Inportant: if its any injury or of once.		1 ☐ Burial 2 🖾 Cremet 4 ☐ Donetion 5 ☐ Othe			ate	ltop S				4/	21/98	Towson	a. Md		
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0	ding Ph h. After th funeral		27. Manner of Death 1 Selection 1 Select	ndina	28e. Dete of (Month,	Injury Dev Year)	28b. Time o	f	28c. Inju	ry et	2	8d. Describe h	ow injury occur	red		
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Division	al or Attanding F s after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, off building, etc. (Specify)								2	8f. Location (S City or Town	treet end Numb n, Stete)	per or Rure	al Route f	Number,
	To the Hospital or Attanding Phymin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	edical	29s. Certifier (Check only 27 Med	dedical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and								end due to	iteted. o the cau:	se(s)		
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	621	ŀ	30. Neme end eddress of per	son who c	ompleted cause	of deeth (Ite	m 23a) (Type,	Print)					-	-		
	ווצו		DR. EDDIE N	AKHUI	A 2300	DULAN	NEY VAL	LEY	RD.	TIMON	IUM.	MD 210	93			
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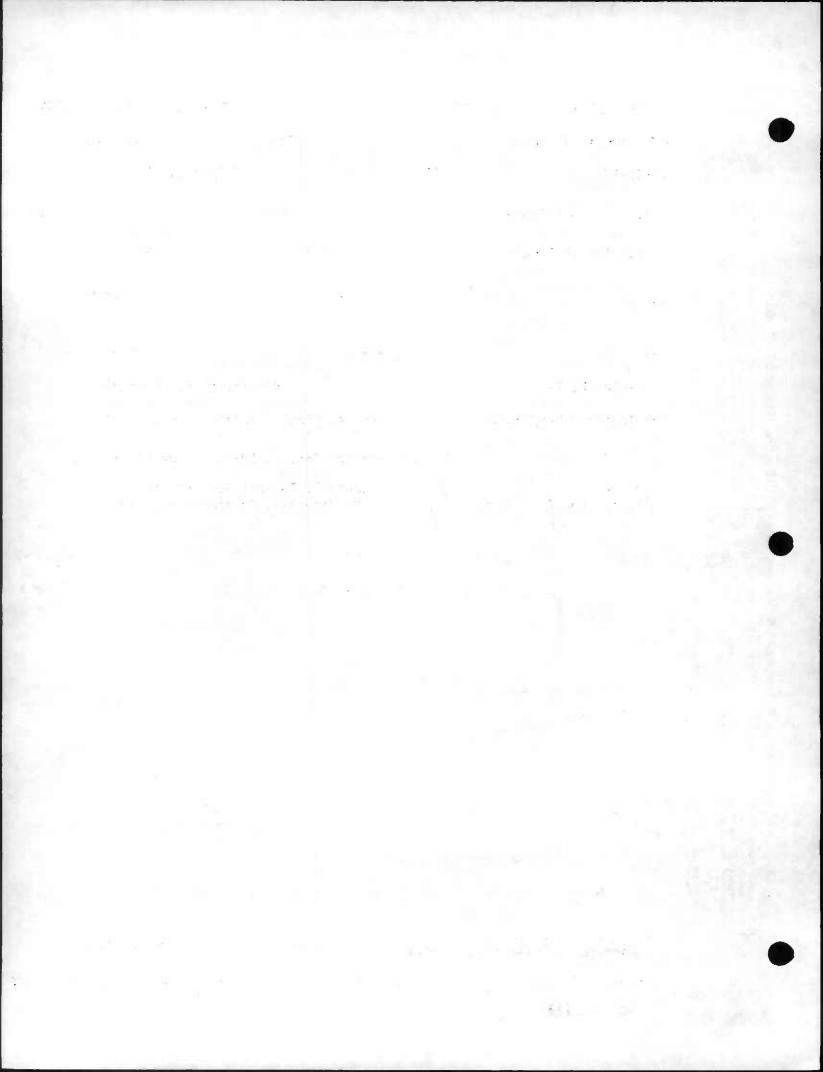
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1:30 pm E. APRIL PATRICIA THOMAS 17, 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner 900 Punjab Circle Essex Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Min. Deys 1 □ M 2 🛛 F Months Hours 52 Yrs Director 212-46-9475 July 14,1945 Maryland Usual Residence of Decedant with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show 10b. County Md. Baltimore Essex 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Punjab Circle ms 23a 21221 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

13. Health and Mental Hygiene.

14. If item 27 is marked other than "natural", or itema 23 my or other traumatic event, the Medical English or mainty. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White þ 3€Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Bingorama Usher 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Charles H. Ey Antoinette E. Olszrwski 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Antoinette Dehne/sister 900 Punjab Circle Baltimore MD. 21221 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 4/22/98 Baltimore Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex plications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast. My 23a. Part 1. Enter the disease, or shock, or heart tailure. List Approximata Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition rasulting in daath) /Medical 5 MINUTES CARDIAC ARREST Examiner Dua to (or as a consequence of): Examiner 3 IEARS AORTIC STENOSIS attending physician end for use es the burial-transit lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown ASTHMA by 24b. Were autopsy tindings available prior to completion of cause of deeth? been si 24a. Was an autopsy Completed s certificata hes t director, page 2 s 1 Yes 2 NO 1 ☐ Yes 2 ☐ No f or Attending Physician: after deeth. 25. Was cese rafarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Panding 1 Yas 2 No Invastigation 2 Accidant ector: 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier å To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number a Malal 30. Nama end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

WALSH, MD MIS W. VARRETTSVILLE RD, JARRETTSVILLE, MD 21084 32 Registrar's Signature



WRC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98-2145-510 State of Maryland / Department of Health and Mental Hygiene DAVID ULLMAN Items: 23 part I,27 per MEO G-758 4/28/98 refertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 16, Day **Physician** DAVID M. ULLMAN, SR. 1998 3:35 PM. /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** 1405 CLARKSON ST. BALTIMORE n/a5. Sociel Security Number If Under 1 Year 7. Age (In vrs. lest birthdev) 8. Defe of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 √M 2 □ F Monfhs Days Hours 212-46-3800 52 Yrs. August 4 1945 Director maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inalde City Limits 7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 12 Yes 2 □ No Baltimore Director Md. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 21230 USA 1405 Clarkson Street Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Sfetus permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or herr any injury or other traumatic average. 1 ☐ Never Married 2 X Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) supervisor Parker Metal 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Pearl J. Smith Charles J. Ullman Sr. 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 154 Berkshire Lane Stewartstown, Penna. 17363 Barbara J. Ullman (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 18,1998Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery **McCully Polyniak Funeral Home 21. Signature of Funerel Service Licensee 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete fnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) BSD 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Onknown Records, þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of death? page 2 has 1 Yes 1 Yes 2 No 2 No certificate Division of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home \$\infty\Residence 6 Other (Specify) P 11 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this 28a. Defe of Injury (Month, Dey Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, streef, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es atated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Rnnis Day, Year)

29b. Signature and title of certifie

hute 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature ia Davidson - Mandall

O.C.M.E.

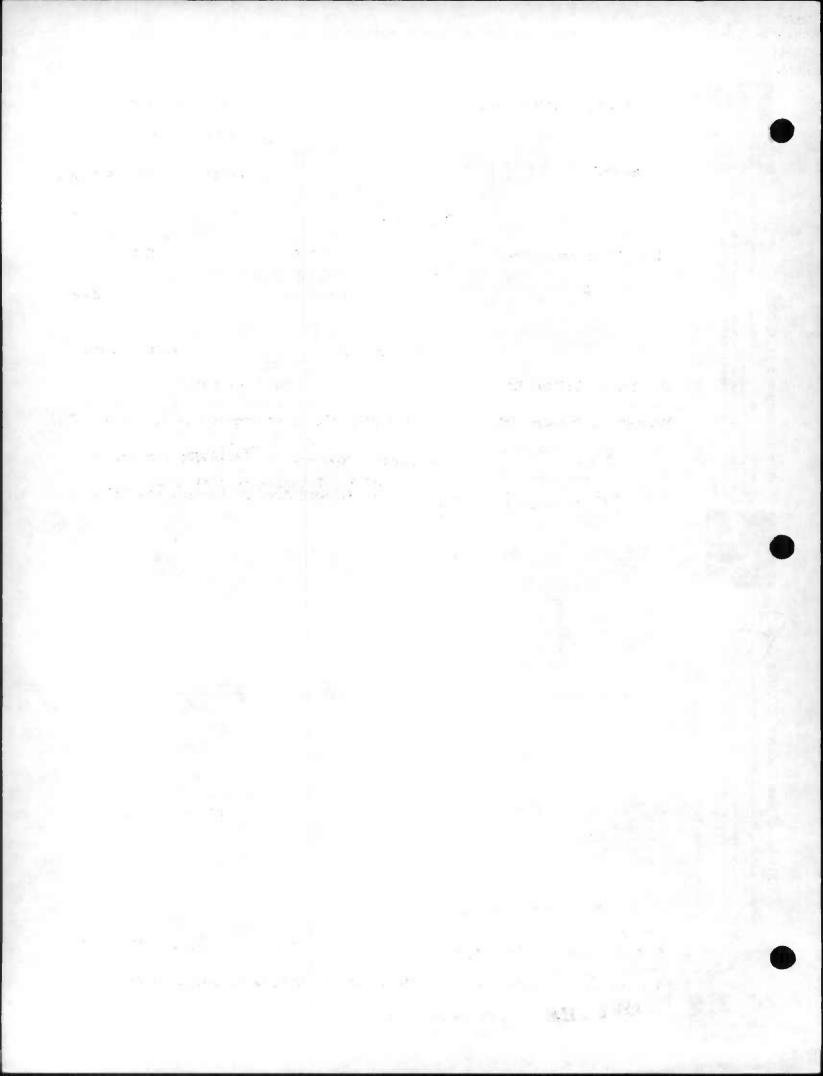
APRIL 17, 1998

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30. Name and address of person was completed ceuse of deeth (Item 23a) (Type, Print)

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Baltimore.	
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		State of Maryland / Department of Health and Mental Hygiene 98 12601										
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min	er	6 Social Sequeity Number 6 S	entlon 70011	V Charle St	Tours		Bal	timore Co.				
ral tor		2/2 22 5 7 52 1 Usual Residence of Decedent	PX 7. Age (In yrs. last)		ays Hours Mi		V, Year)	9. Birthplace (State or Foreign Country) Kentucky				
	Director	· ·	imore 10c. City, To	wn or Location	Owings	Mills		10d. Insida City Limits 1 ☐ Yas 2X□XIo				
		109. Street and Number	Road	10f. Zip Co 2 1 1			10g. Citizan of	What Country? USA				
	by Funeral	11. Maritat Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yaar or Dates:	13. Was Decedent If Yas, specify 1 ☐ Yes 2 ☒	of Hispanic Origin? (Cuban, Mexicen, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Rad Bla Specif	ce - American Indian, ck, White, etc. 'Y' white				
	Be Completed	15. Decedent's Ed (Specify only highest gra	ucation 16 de completed) College (1-4or 5+)	life. DO NOT use re	one during most of watered)			usiness/industry				
!	3	17. Father's Name (First, Middle, Last)		Assembl				rush Mfgr.				
Mental Parkad otl		Albert Bro	own		18. MOTHER \$ IN	Name (First, Middle, Maiden Surname) Janie Watkins						
	ရ	19a. Informant's Name/Relationship (7	Ru <i>ral Rou</i> te Numbe	Route Number, City or Town, Stete, Zip Code)								
t ream and tem 27 is rother traus		Mr. Baden Winte			kmere Ro	ad Owin	gs Mil	1s,MD 21117				
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	cemei	of Disposition (Name of ery, crematory or other orial Bur	place)	Date 4/23/9		City or Town, State				
once.		21. Signature of Funeral Service Licen	Carpenter	22. Name and A Burgee 3631 F	-Henss F alls Roa	uneral d Balti	Home,	P.A. MD 21211				
an		23. Peril: Enter the discrete, or comp shock, or heart failure. List only of	lications/that caused tha death. Do ne cause on each line.	o not enter the mode of	dying, such as cardi	ac or respiratory an	rest,	Approximata Intervel Between Onset and Death				
al er	1	Immediate Cause (Fixed diseasa or condition resulting In deeth)	a. Acule	5 Frake consequence of):				Days.				
	miner		b									
	al Examin	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence of):								
	n/Medica	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
	Physician/M	Part II. Other algnificant conditions co	ntributing to death but not resulting	In the underlying cause	given In Part I.	23b. Did to	obacco use co	ntribute to the cause of death?				
						1 □ Y	'es 2□ No	3 ☐ Probably 4 ☐ Unknow				
	>		240 18/00	in autopsy	24b. Were autopsy findings evallable prior to							
.	pleted by					perfor	med?	completion of cause of deeth?				
	Completed by					perfor						
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	lo be completed	examiner?		Jutpatient 3 DOA	Other: 4 Wursing	perfor 1 □ Y eeth (Check only or Home 5 □ Rasidi	es 2 ANo re) ance 6 Oth	of deeth? 1 □ Yes 2□ No er (Specify)				
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State Registrar Janes H. Carlle Lie

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State of Maryland / Department of Health and Mental Hygiene 98 | 2602

Physician /Medical Examiner uneral	Decedent's Name (First, Middle, L Jennie 4a Facility Name (If not institution, g	ast)										
/Medical Examiner uneral rector		Decedent's Name (First, Middle, Last)										
Examiner uneral rector	4a Facility Name (If not institution, g	Mary Wo	ancowic ₂	Z			April		998 11:00			
rector							or Location of Dea	,				
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	Usuat Residence of Decedent						sept.	13, 1722	Macgana			
8 1	10a. State 10b. County		10c. City, Tow	m or Loca					10d. Inside Ct			
natural, or items 23a or 23a-f show soical Examiner must be notified at letted by Funeral Director	Maryland Balti	more			Balt	imore			1 ☐ Yes			
irec	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Whet Country?			
23a c	9512 Perrybrook	Court		21236				U.S.	Α.			
ver than "natural", or itema 23a or 23a-fs it, the Medical Examiner must be notified Completed by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wa	s Decedent of H	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	No- 14. Raca - American Indian, Black, White, etc.				
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ete our	15. Decedent's l (Specify only highest g	Education rade completed)	16a	(Give kir	nt's Usual Occup nd of work done	during most of	working	16b. Kind of Bu	usiness/industry			
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To Be Comp	19a. Informant's Name/Relationship Robert Wancowic		190	19b. Mailing Address (Stree 300 Montgor								
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	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Position 5 Other (Specific) 1 Removal from State											
	4 ☐ Donation 5 ☐ Other (Spec		Most				4/17/98	Baltimo	re, maryka			
	4 Donation 5 Other (Specify) Most Holy Redeemer Cem. 4/17/98 Baltimore, Maryland 1. Signature of Funeral Service Licensee Schimunek Funeral Home, Inc.											
= 4 0	23a. Part1. Enter the disease, or co	11/		97	105 Bolo	in Rd.	Baltimo	re. MD	21236			
nding physician and usa es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last	a. Me	Due to (or as a	conseque	once of):	C						
signed by the attending of be detached for use e	Part II. Other significant conditions	contributing to death b	out not resulting (sulting In the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of				
b by												
should							24a. Wa	s an autopsy formed?	24b. Were eutopsy t available prior t			
pie									completion of o			
page 2							10	Yes 200	1 □ Yes 2 □			
	25. Was case referred to medical					28. Place of	Deeth (Check only	one)				
3e Con	examiner?	Hospitat: 1 Inpatie	ent 2 ER/O	utpatient	3 DOA OH	her: 4 🗆 Nursin	g Home 5 Res	sidence 6 Oth	ner (Specify)			
Be Silv	1 ☐ Yes 2 No	28a. Date of Inju (Month, Da	lry Year) 28b.	Time of tnjury	28c. Inju Wo M 1	ryet irk?]Yes 2 ☐ No	28d/ Describe	how Injury occur	rred			
To Be	1 Yes 2 No 27. Manney of Death 1 Netural 5 Pending 2 Accident investigati	2 TAccident Investigation 2 Taccident 2										
To Be	27. Manner of Death 1. Netural 2. Accident 3. Suicide 5. Pending investigati	be 28e. Plece of Inj	jury - At home, fa c. (Specify)	arm, stree	t, factory, office				ber or Rural Roufe Num			
led in by the funeral director.	27. Manner of Death 1 Metural 2 Accident 3 Suicide 4 Homlcide 29a. Certifier 27. Manner of Death 5 Pending investigati 6 Could not determine	be 28e. Plece of Injuding, et	of my knowledge f exemination or	e, death o	ccurred at the ti		City or To	own, Stete) e ceuse(s) end me				
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8" - 1. 15 - 17 4 E2: 1 may well regular medium. Fig. 1. 3 THE RESIDENCE 16,50% 5 20,0%

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** April Robert Richard Wilson, Sr. 1998 11:35 PM 14, /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Securify Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) 6. Sex 120 M 2□ F **Funeral** Days Months 219-30-3839 Yrs. 63 Feb. 17, 1935 Maryland **Director** Usual Rasidanca of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!, or items 23a or 28a-f show any injury or other traumatic event, in Medical Examples noutled. 10a Stete 10b County 10c. City, Town or Location 10d, Inside City Limits 1 Yas 2 No Maryland Baltimore Kingsville Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11835 Gontrum Road 21087 U.S.A. Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 IZYes 2 No If Yas, Giva Konean Yaar or Datas Conflict 14. Raca - American Indian Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus Black, Whita, afc. 1 Navar Marriad 2 Married 1 Yas 2 X No Specify: Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast greda completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Communications 8th grade Machine Operator Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) William C. Wilson Louise Heiger 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Neme/Raletionship (Type, Print) 11835 Gontrum Road, Kingsville, MD Shirley M. Wilson (wife) 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 4/18/98 Elkridge, Maryland 4 Donation 5 DOthar (Spacify) Entombment Meadowridge Mem'l Park 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21. Signatura of Funaral Sarvice Licensaa Buin a. Willen 21236 23a. Pert1. Enfer the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata intarval Batwean Onsat and Daath Physician /Medical Immediata Causa (Final Myocardial Infantion. diseasa or condition rasulting in daath) Examiner Examiner attending physician and for use es the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or injury fhat Initiated avants rasulting in daath) Lasf Dua fo (or as a consequanca of): Physician/Medicai Due to (or as a consaquanca of): 80 signed by the a 23b. Did tobacco uaa contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings

available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 2 No 1 Yas 1 □ Yas 2 □ No or Attending Physician: Be 25. Was casa rafarred to madical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No 3 DOA Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient Aftar this funeral 28c. Injury et Work? 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not ba datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homlcida Hospital 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifian Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar 31. Data filed (Month, Day, Yaar)

29b. Signatura and titla of certifian

APR 2 11998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print).

MOHAMMAD TAPIMD BRENTWOOD MD CENTER 6710 Holbird NEW BULL MD 21222 32. Registrar's Signatura Julia Davidson-Randala

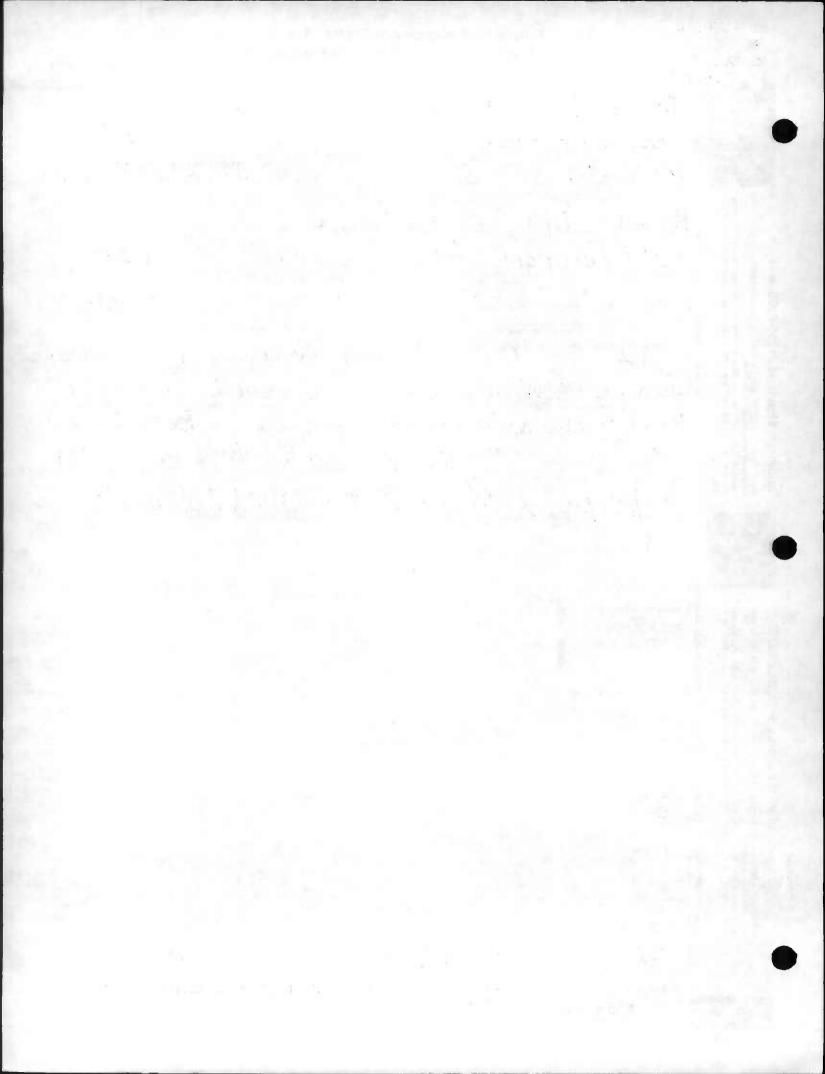
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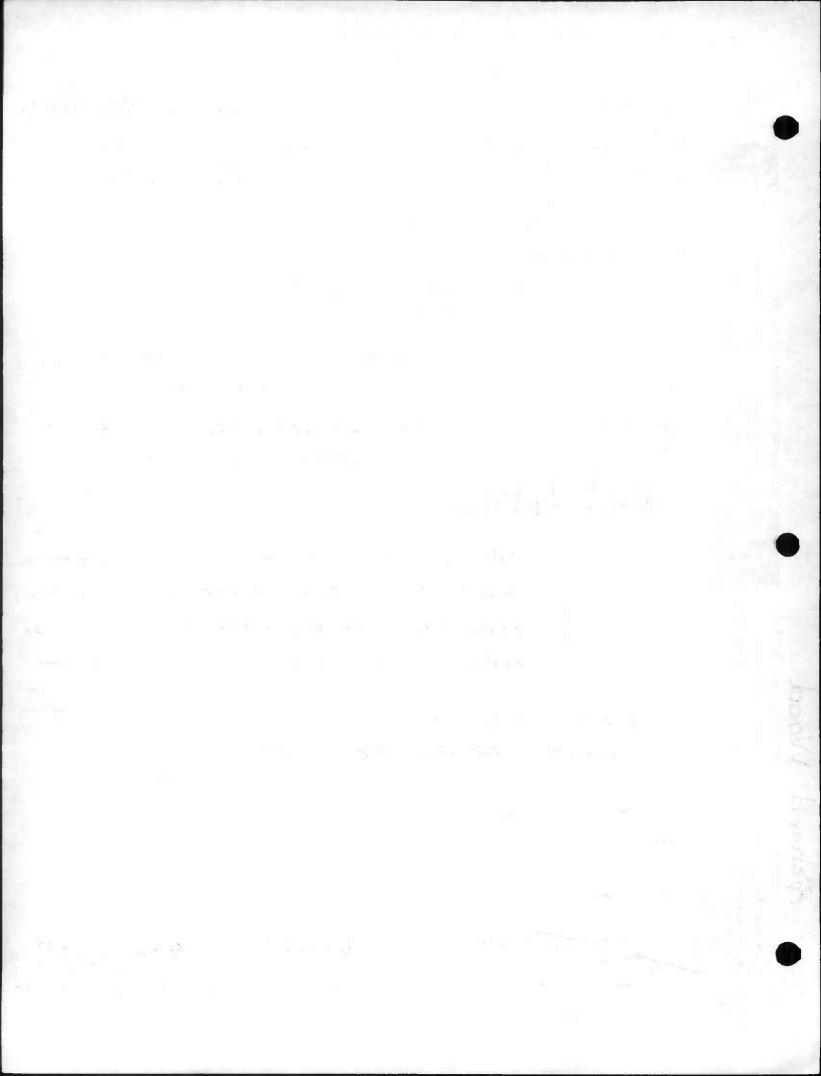
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State of Maryland / Department of Health and Mental Hygiene

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100	Physici /Medi		Richard A. Wood						APRIC	- 16 1	998	11:45	An
	Examir		4a. Facility Name (If not institution, give	street end number)				4b. City, Town, or i	Location of Deat	th 4c. Count	y of Death		
			Union Memorial	Hospita	1			Baltimo	re	Balt	imor	0	
	Funeral		5. Social Security Number 6. Sec			last birthd	ay) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Bi	rth av Year)		ace (State or Fo	oreign
	Director		308-30-0403	3 M 2 L F	65	Yrs		, , , , , , , , , , , , , , , , , , , ,		8,1932			
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	with the Marylend or 28s-1 show	Director	10e. Street and Number	Arunder	L1	nthi	10f. Zip Code			10= Chinas -4	Mark Course		
	2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show surnatic event, it a Madical Examinar mant be notified at		207 Hance Avenu	_						10g. Citizen of	200		
	72 hours after death w natural", or items 23s	Funeral			Ever In I I	Q 1	2109		pacifu Vac or N			States - American Indian,	
	ter d	5	1 Never Married 2 Married	12. Wes Decedent Armed Forces? 1 ☑ Yes 2 ☐ 1			If Yes, specify C	of Hispenic Origin? (S uban, Mexican, Puert	orto Rican, etc.)				
21215-0020	ors af	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	4/	51	1□ Yes 2XIN	lo Specify:		Speci	y: whi	te	
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<u>a</u>	Aents Aents rked fic e	To	Harry M. Wood					Sarah	M. Boo	mershi	ne		
Maryland	d 2 should thend Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of							er, City or Town	, Stata, Zip	Coda)	-
	Dat 7.		Rick Nelson, son 134 Canterbury Rd. Cir								s. M	N_5301	4
Baltimore,	es 1 en of Heal f item 2 r other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	Inmercal from State	20b. F	Place of Dicematary, of	sposition (Nama of cramatory or other p	place)	Date	20c. Location	- City or Tov	vn, State	
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	/Medical		Immediate Cause (Final disease or condition	100	D.'A	6 G	olie.	SHOCK				1.1.	
	Examiner		resulting in death)								1	ly hou	N
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200	pital or Attending Physician: ours efter death. eral Director: After this certific filled in by the funeral director,	Ë	27. Manner of Death	28a. Date of Injur (Month, De)	y Year)	28b. Time Injur				how injury occu			
ichay Division o	tendin death. tor: Afr	atic	1 Naturel 5 ☐ Pending 2 ☐ Accident Investigation	(month, Do)	, , , , ,	iiijoi		☐ Yes 2☐ No					
\(\frac{1}{2}\) \(\frac{1}{2}\)	or Atten efter deat Director: I in by the	tifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At ho	ome, farm,	street, factory, offic	Э	28f. Location	(Straat end Num	ber or Rural	Routa Number	
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a	Hospital of 24 hours e Funeral Dietely filled	cai	29a. Certifier Sertifying Phys	sician: To the best of	of my kno	wledge, de	eath occurred at the	time, date and place y opinion, death occu	, and due to the	cause(s) end m	enner as sta	ited.	
	within 24 ho	Médicai	one)	and manner ste	ted.	and/of			., 50 et 1118 111119,				
	To the within 2	3	29b. Signature and title of certifier	= MD				ense number		29d. Date sign			
	KD	1	A	111			Dr	41637		MARI	217	,189	8
	9	1.	Name and andress of person who co	mpleted ceuse of d	eath (Item	n 23e) (Typ	oe, Print)				MO	2121	8
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State of Maryland / Department of Health and Mental Hygiene 8 2606

							Certificate of		Reg. No.		12000	
	Phy		an	Decedent's Name (First, Middle, Last) ONLY OF						eath Day	Year	3. Time of Death
	d	Physici /Medi		LOUISE	V		WEINGL		Month APRIL	, 16	1998	1:58 AM
•		Exami		4a. Fecility Neme (If not institution, give street and number) GILCHRIST CENTER - HOSPICE OF I				N		BALTIMORE		
		Funeral Director	To Be Completed by Funeral Director		D	(In yrs. last bir	thdey) If Under 1 Yea Months Dey		8. Date of Bl Month, D JULY I	7,1942		olece (State or Foreign htry) YORK
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any linky or other treumatic event, the Medical Examinations to notified at once.		10a. State 10b. County 10c. City, Town or Location							1	10d. inside City Limits 1 ☐ Yes 2 💆 No
				10e. Street and Number 7107 PHEASANT CROSS DR.			10f. Zlp Code 21209			10g. Citizen of What Country? USA		ntry?
	020			11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes, Sive Yeer or Dates:			in U,S. 13. Wes Decedent of Hispenic C if Yes, specify Cuban, Mexico 1 ☐ Yes ※☐ No Specify				14. Race - American Indi Black, White, etc. Specify: WHT	
	15-0			(Specify only highest grade completed)			Decedent's Usual Occ (Give kind of work don	rking	16b. Kind of Bus		siness/industry	
	212			Elementary/Secondary (0-12)	nentary/Secondary (0-12) College (1-4or 5+) SECRETARY					LEGAL		
	and			17. Father's Name (First, Middle, Last) HYMAN BAY						(First, Middle, Maiden Surname)		
7.	Mary			19a. Informant's Name/Relationship JACK WEINGLASS		BAYLISS ROSE UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 7107 PHEASANT CROSS DR. BALTIMORE, M					, State, Zip	21209
8 A.H.	Baltimore, Maryland 21215-0020			20a. Method of Disposition 1 □ Buriai 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removel from State	20b. Placa of cemeter	of Disposition (Name of tery, crematory or other place) AN ABRAHAM 4/19/98 ROSEDAL					own, State
5/0	Baltii			21. Signeture of Funeral Service Lice			22. Name and Add	VINSON & E	BROS., I	INC.		MD 21208
8661-9	•	Physician /Medical Examiner		23a. Past Enter the disease, or considered to have failure. List only immediate Cause (Final disease or condition resulting in death)	a. Mu	fast		ying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death 3 years
Apail - 11	Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burns rate feedeath. To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burnu-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last b. Due to (or as a consequence of): c. Due to (or es e consequence of): d.								
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ouise V.	Division of			27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day	Year) 28b. 1	ime of 28c. Injury	ury at ork?	28f. Location	how injury occu		al Route Number,
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DHMH 16 Ray 6/95

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Medical Examiner	A CONTRACTOR OF THE PARTY OF TH	4e Fecility Neme (If not institution, give street end number) LEVINDALE HEBREW HOME					4b. City, Town, or Location of Death BALTIMORE		4c. County of Deeth N/A			
Funeral Director	5. Sociel Security Number 216–32–2946 1 M 2 F 90 Yrs. Sociel Security Number 216–32–2946 1 M 2 F 90 Yrs. Sociel Security Number 216–32–2946 1 M 2 F 90 Yrs. Sociel Security Number 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birth (Month, Dey, Year) APRIL 29, 1907 Light Number 29 1907 1									9. Birthple Country 7 LITH	ce (Stete or Fo	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month 04 5:25 Am Rosina Comfort Wiggins 20 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, giva street and number) 4c. County of Death r Nursing Home 7. Age (In yrs. last birthday) Yrs. Rundar 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) JULY 24, 1908 Sandtown Winchester Nursing Home N/A Birthplace (State or Foreign Country) 5. Social Sacurity Number 1□M 2□XF 217-30-5164 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 XYas 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 1000 N. Gilmor Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify: 3 ₩idowed 4 Divorced Black 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Louis Speaks Mary Kellum 19a. Informent's Name/Relationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4606 Coleherne Rd Baltimore, MD 21229 Leon W. Speaks/Son 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 4/21/98 Baltimore, MD Cremation Society of Maryland Inc. 21. Signature of Funeral Service License Dawn F. McDonald Cremation Society of Mar 299 Frederick Road Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Baltimore, MD 21228 Approximete interval Between Onsat and Death Acuto Cezeporo Voscular Accedent Immediata Ceuse (Final disease or condition resulting in deeth) ypee teusen Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Dua to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? Deseaso 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of ceuse 24e. Was an autopsy performed?

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification:

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31. Date filed (Month, Day, Year)

mportant: If item 27 is

6

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f sho treumstic event, the Medical Examiner must be notified at

physicial a

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director,

State Registrar

				1 ☐ Yes 2 XNo	of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical	26. Plece of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐ DC	Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigetic		28b. Time of tnjury M	8c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	be					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homlcide determine		home, farm, street, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) Certifying P	Physician: To the best of my kn aminer: On the basis of examinand menner stated.	nowledge, death occurred a nation and/or investigation,	at the time, dete end plece in my opinion, death occu	e, end due to the ceuse(s) end mar arred at the time, date end place, a	nner as steted. and due to the cause(s)					

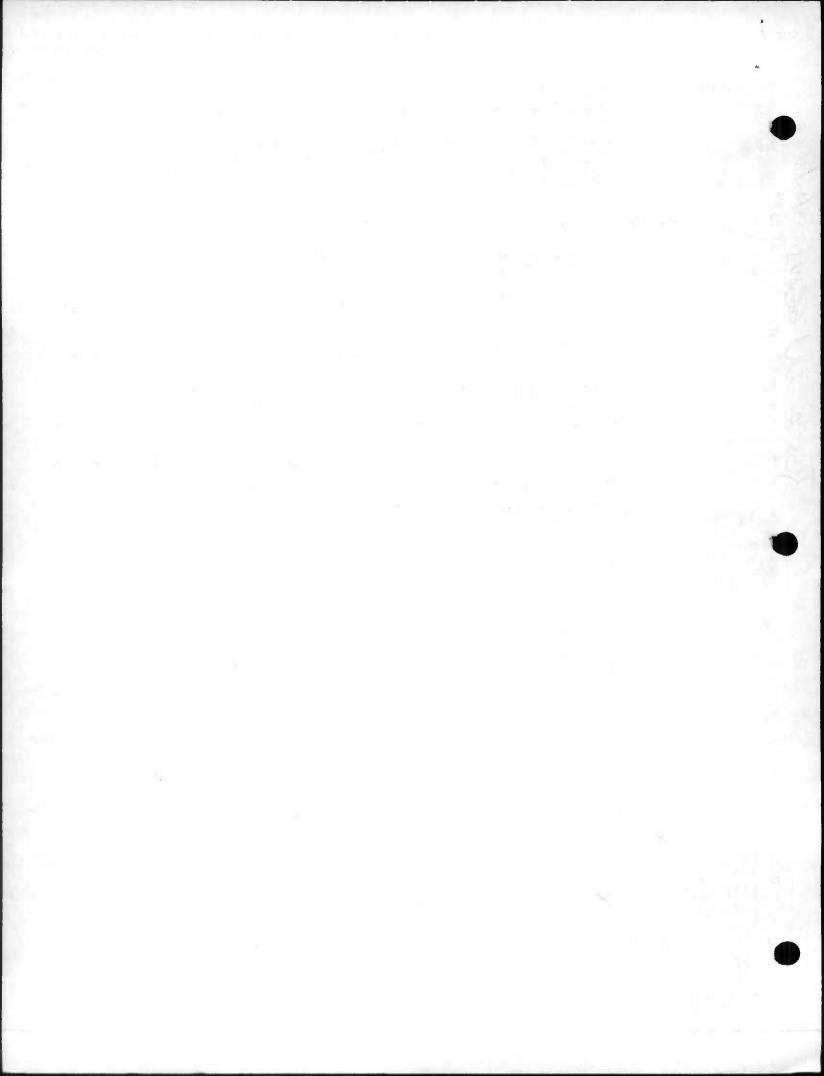
29b. Signature and title of certifiar aberri

29c. Licansa number D26798 A

29d. Data signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 4419 FALLS ANIL LABEROS

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DAVID

WIT	DMER	

98-2152-021

State of Maryland / Department of Health and Mental Hygiene

of Death	Reg. No.	ı	2.	U	U	8
Health and Menta	II Hygierie		2	6	0	0

111 Penn Street, Baltimore, Maryland 21201

	Physician
1	/Medical Examiner
	Examiner
	Euporol

Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "naturel", or fisms 23a or 28a-f show sny injury or other traumetic svent, the Medical Examina.

Physiclan /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificated within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physical.

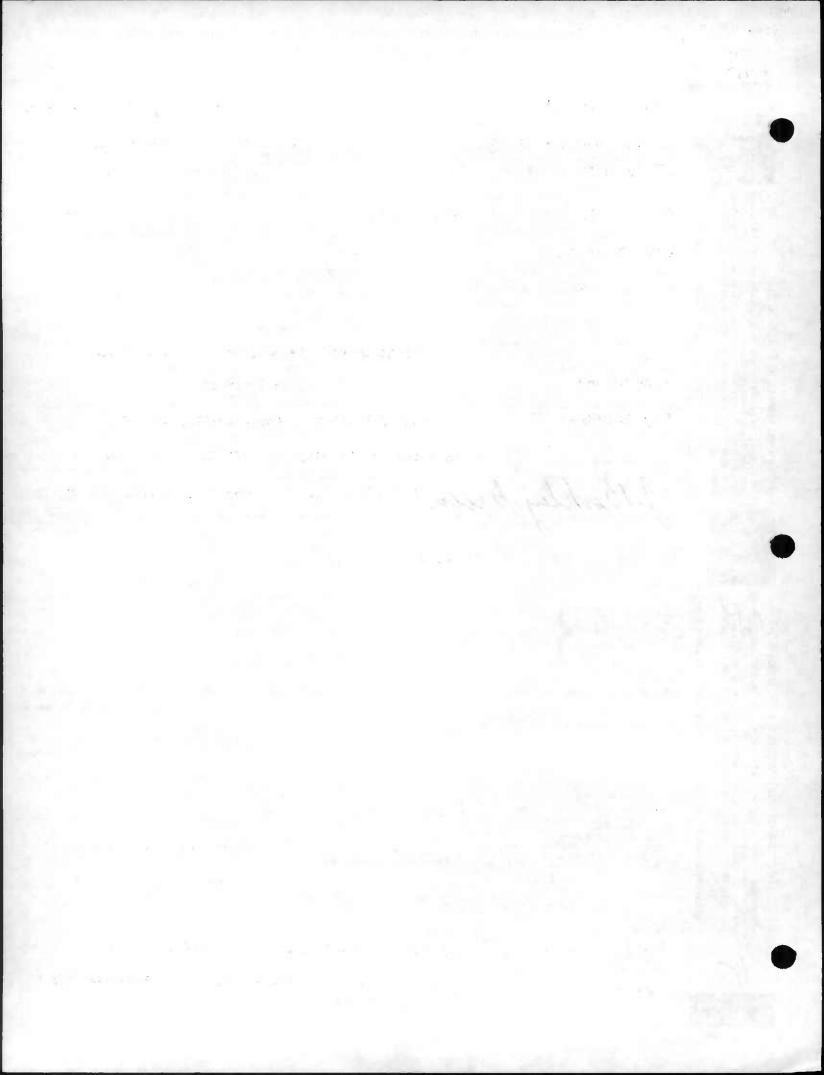
Division of Vital Records, P.O. Box 68760,

Stephen S. Rade
31. Date tiled (Month, Day, Yaar)
APR 21 1998

									Reg. No.		
1. Decedent's Name (First, Middle, Las								2. Dete of D Month	eeth Day	Yeer	3. Time of Death
David Allen Widr	ner							APRIL		1998	9:34A.M
4e Fecility Name (If not institution, give	street end nun	nber)				4b. City, T	own, or L	ocation ot Dee	th 4c. Co	unty of Deat	h
FREDERICK MEMORIA				. Hillada	er 1 Year		DERIC			EDERIC	
224-17-0250	M 2□F	7. Age (In yrs. 36	Yrs.	Months		Hours		8. Date of B (Month, D 11-3-	ley, Year)		hplace (Stete or Fore puntry) /A
Usual Residence of Decedent 10a, State 10b, County		10c, Ci	ty, Town or L	ocation							10d. Inside City Lim
VA Loudour	1		vettsv								1 ☐ Yes 2 🔼
10e. Street and Number 12902 Booth Rd.					ip Code 180				10g. Citizen USA	of What Co	ountry?
11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Yeer or Da	rces? 2X No e	J,S. 13.	Was Dece If Yes, spe 1 \(\text{Yes} \)		Hispenic C ean, Mexico Specifi		pecify Yes or N Rican, etc.)		Race - Ame Black, White ecify: Wh	
15. Decedent's Ed (Specify only highest grad	ucation de completed)		16e. Dece (Give	edent's Usu e kind of we DO NOT	ual Occup ork done	pation during mo	st of worl	king	16b. Kind	ot Businass/	Industry
Elamantary/Secondary (0-12)	College (1-	-4or 5+)		ironm					Chom	ical C	30
12 17. Father's Name (First, Middle, Last)	4		LHIV.	TLOIM	CIICA			e (First, Middl			
Ralph Widmer						Diar	na Sh	epherd			
19a. Intormant's Name/Raiationship (7 Mary Jo Widmer	ype, Print)							ral Route Num			
20e. Method of Disposition		20h	Plece of Disp			RO.,	rove	ttsvil	1		Town, State
1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Ctoto	cometery, cre	emetory or	othar pla		7 4	/21/98		andria	
	100	,	/ 2	22. Name a	and Addre						
23a Marti. Enter the diaease, or compensor, or heart failure. List only	4/3/	ULV aused the dea ach lina.		PO Bo	x 38	5, 72	21 E1	den St		ndon,	VA 20172 Approximata Interval Between Onset and Death
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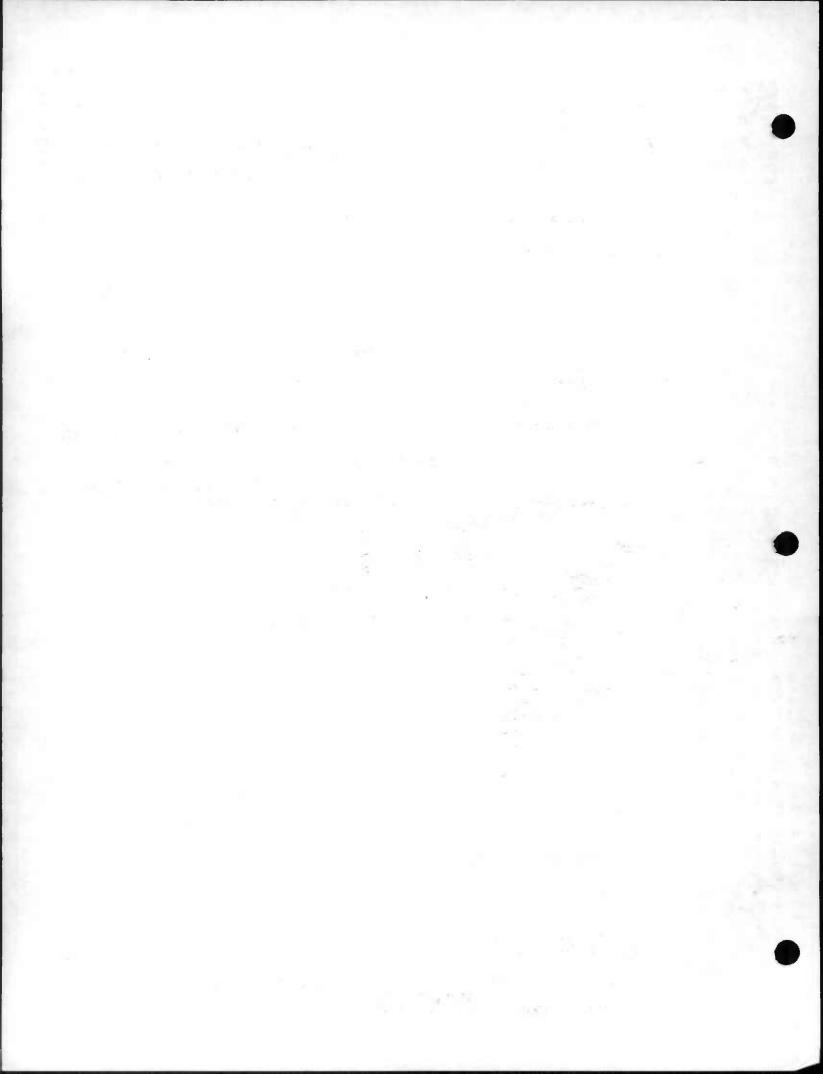
32. Registrar scienatural Pandata

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_						Certificate	e of L	Death		Reg. No.	12611	J
	Physic	ian	1. Decedent'a Name (First, Middle, Las	t)					2. Date of Dea Month	ith Day	3. Time of Yeer	Death
Ų,	/Medi	cal	Edwin Earl	Wyatt			- 4	City Tourn or I	April	18, 199		0 P.M
и	Exami	ner	4a. Fecility Name (If not institution, give				41	o. City, Town, or L				
Н	Funeral				(In yrs. last bin			Annapol If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State o. Country)	or Foreign
	Director	ı	450-18-2192 Usual Residence of Decedent	ØM 2□F	86	Yrs. Months	Deys	Hours Min.	Novembe	r = 5,191	1 Texas	
	how		10a. State 10b. County		10c. City, Town	or Location					10d. Inside Cit	
	Sa-f	Director	Maryland Anne Ar	rundel		Annapol					1 🗆 Yes	2 💢 No
	23s or 2	rai Dir	10e. Street and Number 1176 River Bay F	Road			2140			10g. Citizen of V US		
Maryland 21215-0020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Wes Decede If Yes, speci		spanic Orlgin? (Sp n, Mexicen, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Blac Specify	e - American Indien, ck, White, etc. White	
5-0	72 h	etec	15. Decedent's Ed (Specify only highest grad	ucetion de completed)	16a.	Decedent's Usuel (Give kind of work	k done d	u <i>ri</i> ng most of worl	king	16b. Kind of Bu	usiness/industry	
12	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Teacher	e retired)			F 4		
9	be filed withintel Hygiene. Id other then		17. Father's Neme (First, Middle, Last)	JT		reache		18. Mother's Nam	ne (First, Middle,		lucation	
lan	0 5 5 9	To Be	T. Scott Wyatt					Ethel	Pear1	Dickey		
ary	d 2 should th and Mer 7 is marks traumatic	-	19a. Informent's Name/Relationship (7	ype, Print)	19b.	Mailing Address	(Street e	nd Number or Ru			Stete, Zip Code)	
Σ,			Sondra Gray - Da	aughter	_ 1	176 Rive	r_Ba	y Road,	Annapoli	s. MD 2	1401	
Baltimore,	t of H If iter or oth		20a. Method of Disposition 1 Burial 2 X Cremation 3 D	Removal from State	20b. Place of cemeter	Disposition (Nam y, cremetory or other	ne of ther place)	Date	20c. Location -	City or Town, State	
	tmen tant: jury		4 □ Donation 5 □ Other (Specify)	Metro	Cremato			Apr. 20	Baltimo	ore, MD	
Bal	permit. Pages 1 end Depertment of Health Important: If Item 27 eny injury or other t		21. Signature of Funeral Service Library	gr.)		22. Neme and		s of Facility S ain Road			1 Home, P.	Α.
	100		23a. Pert1. Enter the discuse, or comp shock, or heart failure. List only of	lications that causes	the death. Do r	not enter the mode	of dying	, such as cerdiac	or respiratory ar	rest,	Approximate Intervat Bety	e ween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)			ary arre	st				Onset and D	Deeth
	D #	ner				consequence of): theroscle	oroc	ic				
	icete be executed physician and s the buriel-transit	Examiner	Sequentially list conditions,	b. defici d	Due to (or as e o	consequence of):	ei us	13				
68760,	be ex		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	_{c.} Partia	1 smal1	bowel of	bstr	uction				
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	gned be de	by F	chronic osteomye	elitis let	thip							
or vital Records,	law requires that the death certificete be executed es been signed by the ettending physician and 2 should be detached for use es the bunel-transit	Completed							24a. Was o	en eutop <i>s</i> y med?	24b. Were autopsy fi available prior to completion of ca of death?	0
Ĭ	0 - 0	E							1 D Y	es 200 No	1 Yes 2	No
La		Be	25. Wes case referred to medical examiner?					26. Plece of Dee	th (Check only o	ne)		
2	Physician: this certific ral director,	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatie				4 Li Nuising H	ome 5 💢 Resid			
IVISION	Attending P r death. ector: After iby the funer	ation:	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. T	ime of 28 njury M	Bc. tnjury Work 1 ☐ Y	at ? ′es 2 □ No	28d. Describe h	ow Injury occurr	ed	
NIN	Ital of Atte frs after de of Directo led in by ti	Certification:	3 Suicide 6 Could not be 4 HomIcIde determined	28e. Place of injubulding, etc.	ry - At home, fai . (Specify)	rm, street, factory,	, office		28f. Location (S City or Tow	itreet end Numbern, State)	er or Rural Route Numi	ber,
R	Hosp Z4 hosp Fune	edical	29a. Certifier (Check only one) 1	sician: To the best of iner: On the basis of and manner sta	examination and	, death occurred a Vor Investigation,	it the time In my op	e, dete end place, inion, death occur	and due to the orred at the time, o	ause(s) end me late and place, s	nner as stated. and due to the ceuse(s))
	within To the comple	M	29b. Signature end title of certifier,			29c.	License	number		29d. Date signed	d (Month, Dey, Year)	7-7-
			M Mullin	, mp			0263	75		April	20, 1998	-
7			M. Mullins, MD 5	ompleted couse of de 86 Reller			2 P	Annanc	lis MD	21/101		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrá	s lighal a	son Mandel	, <u>L</u> D	, Alliapu	iis, MU	L1401		
	Registr	95.9	APR 21	1998 1	was David	son yander	34					



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Dafa of Death afril Dorothea Louise Watts 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Locution of Daath 4c. County of Death Mariner Health Care of Bel Air Bel Air Harford Co. 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 6 Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yeer) Birthplaca (Stata or Foraign Country) 1 M 2CKF Months Days Hours 83 217-07-5243 Sept.12,1914 Baltimore, Md. Usual Rasidence of Decedani 10e Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Maryland Harford Co. Bel Air 10e. Sfreet and Number 10f. Zip Coda 10g. Citizan of Whef Counfry? 915 East Broadway 21014-3347 United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No 1 Navar Married 2 Married 1 Yas 2 No Specify: 3 X Widowed 4 □ Divorced White 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Book Keeper n/a Butcher Shop 17. Fathar's Nama (First, Middla, Last) 18 Mother's Nama (First, Middle, Maiden Surnema) John Louis Hogarth Sarah Elizabeth Moreland 19a. Informant's Nama/Ralationship (Type, Print) (Daughter) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 915 East Broadway Mrs. Sarah J. (nee Watts) Barnes Bel Air, Maryland 21014-3347 20b. Place of Disposition (Name of cematery, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery 4/20/98 Baltimore, Maryland 21. Signature of Funaral Sarvice Licensas Jeffrey L. Gair 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. an 1050 York Rd. Towson, Md. 21204 23a. Part1. Enfar the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediate Causa (Final UROSEPSIS 15 DAYS disaasa or conditior rasulting in daath) Dua to (or as a consequance of): Sequantially list condiflons, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yee 2 No 3 Probably 4 Unknown SYNDROME 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? LEFT CEREBRAL INFARCT 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medicel examinar? 28. Pieca of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of 1-Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant

Examiner physician, s the burta Physician/Medicai The law requires that the death certificate the signed by the þ Completed s certificate hes t director, page 2 s or Attanding Physician: Be Certification: To Director: To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Directo

Funerai

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner mant be notified at

with the Marylend

death

72 hours efter

filed within el Hygiene.

Baltimore,

Peges 1 and 2 should be filt ment of Health and Mentel Hant: If itam 27 is marked oth jury or other traumatic even

Department of Important: If any Injury or pace.

Physician /Medical

Examiner

1 Yes 2 No 27. Mannar of Death

> 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to tha ceuse(s) end menner es steted.
>
> 2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

(Check only one) 29b. Signatura and fitla of certifiar

3 Suicida

29a. Certifier

4 Homicide

29c. Licansa number D08096 29d. Data signed (Month, Day, Year)

Andrew Nowalionshops 30. Nama and addrass of parson who completed ceusa of death (itam 23a) (Type, Print) MP MNOREN NOWAKOWSKI

APRIL 17, 1998. 125 NMOWN ST. BERATR, MDLANY

State Registrar

edical

31. Data filed (Month, Day, Year)

6 Could not be detarmined

Julia Davidson-Mandall 32. Ragistrar's Signature

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Year **Physician** ROSE WARD ELLEN April 19, 1998 11:35 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 404 Rambler Rd. Bel Air Harford Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 1□ M 20 F Hours 216-50-1348 49 Director May 6, 1948 W. Va. Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 TYes 2 No Director Md. Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Rambler Rd. 21014 IISA Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Never Merried 2 Harried 1 ☐ Yes 2 No 1 Yes 2 No Specity: Specify: þ Yeer or Detes: 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Vice President Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Paul Linville Annie Dancy 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mr. William C. Ward/husband 404 Rambler Rd. Bel Air, Md. 21014 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/22/98 Lake View Cemetery Sykesville, Md. 21. Signature of Funerel Service Lica 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Preumoma diseese or condition resulting in deeth) 1 week Examiner Due to (or as e consequence of): Examiner months -ung cancer Due to (or es e consequenca of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest and Box 68760 The law requires that the death certificet Physician/Medical physic Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Was an eutopsy Completed has page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affar this certifical completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residenca 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA P 1 Yes 2 No 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dev. Year) 29c. License number 29b. Signeture and title of certifier Weyle MD 123809 /20/98 autin 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) Cancer Ctr., 22 S. Gream St., Bult, MD 21201 Austin Doyle Greeneloum 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State APR 21 1998 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Day Month April 19, 1998 11:00 AM Guerrino Anthony Yori 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 5400 Radecke Ave. 5. Sociel Security Number If Under 1 Y If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 6. Sex 7. Age (In vrs. lest birthday) Days Hours 1**32** M 2□ F Months 09-21-1921 Maryland 219-30-6021 Usual Residance of Daceden 10d. Inside City Limits 10e. Stata 10b. County 10c. City, Town or Location 1 Yes 2 □ No Maryland 10e. Street end Number N/A Baltimore 10f. Zip Code 10g. Citizan of What Country? U.S.A. 21206 5400 Radecke Ave. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give Yeer or Detes: Bleck, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Brewery 7-Years 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Beatrice Pannoni J. Yori John 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1005 Fox Ridge Lane Baltimore, Maryland 21221 Yori (Son) Dominic A. 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 4-22-98 Parkville, Maryland Parkwood Cemetery 21. Signature of Fuheral Servica Licansee 22. Neme end Addrass of Facility Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD J. Wayne Osterling he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, it failure. List only one cause on each line. Approximete Interval Betwean Onset and Death Cancer (Oat(ell) Immediete Ceuse (Final disaasa or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disaesa or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequanca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown reumatoid 1 Nos 2 No 24b. Wera autopsy findings available prior to 24a. Wes en eutopsy performad? complation of cause of daeth? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Othar (Specify) 2170 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury et Work? 5 Panding investigation 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide

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Physician

Examiner

Funeral

Director

7 is marked other than "natural", or itams 23s or 28a-f show traumatic event, the Modical Examiner must be nothled at

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Pages 1 and 2 should be filed within hert of Health and Mental Hygiene. Int: if item 27 is marked other than 1

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Box 68760 Division of Vital Records, P.O. ofter death Director: filled in by 8 Hospital 24 hours

25. Was case referred to medical examiner? 1 Yes 27. Mannar of Death
1 Natural
2 Accident

4 Homicida

29a. Certifie

6 Could not be datermined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceusa(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

Stolloch Rovan Blud md. 21239

(Check only one) 29b. Monature and title of certifie

29c. License number

29d. Date signed (Month, Dey, Year) 4-20-98

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

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31. Data filad (Month, Day, Year)

32. Registrer's Signeture with Davidson Randolle

Registrar

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State of Maryland / Department of Health and Mental Hygiene			
	State of Maryland / Department of Health and	Mental Hygiene	8

Physician (Medical Examiner 1. Decodent's Nama (First, Middle, Last) Bernard John Zeller, Sr. Security Name (First, Middle, Last) Bernard John Zeller, Sr. April 13, 1998 4:45 7 April 13	Merelgn
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29c. Licansa number 29d. Data signed (Month, Day, Year)	
19 MMhmykley, mp 025205 April 14, 1998	
30. Nema and addrass of person who completed cause of dear (Nem 13a) (Type, Print) N. A. K. Ley G. C. G. T. N. Charles St. BALto. V. State 31. Data filed (Month, Day, Year) 1000 32. Registratic Signature Fundable 2(20)	11
State Registrar APR 2 1 1998 32. Registrate Signature APR 2 1 1998	V 6 "

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: item #17 Per FH Film G758 4-21-98RC Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** se/mo April 0/20 /Medical 4a. Fecility Neme (If not institution, give street end number) Oity Town, or Location of Deeth 4c. County of Deeth **Examiner** ANDALISTAIN Northwest tospital ENTER DACTMONE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) APR - 17, 1898 5. Sociel Security Number Sex ≠□M 2□F 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) **Funeral** Min. Months Devs Hours 122-44-5192 Yrs 100 Director POLAND Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner invest be nortifed at MD BALTIMORE COCKEYSVILLE 1 XYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10207 GREENSIDE DR. 21030 COSTA RICA deeth v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 14. Rece - American Indien, permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic available. Bleck, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No WHITE Specify þ **⊉**□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) OWNER CLOTHING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) **GUDALIA** GADALIA ZEITUNG SARA GERSTENZANG 2 19e. Informant'e Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. OFELIA APTER (DAUG.) 2118 BURDOCK RD. BALTO., MD 21209 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State BETH EL MEM. PARK 4/19/98 RANDALLSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Namo and Address of Each & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 tions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, cause on each line. Approximete intervel Between Onset end Deeth Physician Sepsi Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner Bowel Obstraction attending physician add for use as the burial-transit tha deeth certificete be axecuted Sequantially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) 88 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ should be 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Deen page 2 certificate has 2 NO 1 Yes 2000 1 🗆 Yes 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_o 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpetlent 3 DOA this 28e. Deta of Injury (Month, Day funeral 27. Manner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident Attending 5 Panding investigetion death. 1 Yes 2 No after death Director: / the 6 Could not be datermined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide Hospital of 24 hours 8 24 hours a 11 Certifying Physician: To the best of my knowledga, deeth occurred at tha tima, data and place, and dua to tha cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, data and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date/signed (Month, Day, Year) 29b. Signature and title of centille

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32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene |

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Completed by Funeral Director 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Spacify: 3⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Postal Service Worker unknown unknown 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19a. Informant's Name/Ralationship (Type, Print) Department of Health as Important: if Item 27 is any injury or other traconce. Mary Zimmerman/daughter unknown 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 5 Cher (Specify) in state 21. Signature of Ronald S. Wade, Director Baltimore, Maryland 21201 Enlar the disease, or complications that ceusad the deeth. Do not anter the moda of dying, such es cerdiac or respiratory arrest, or heart failura. List only one causa on each line. **Physician** /Medical Immediata Causa (Final URUSEPSIS disease or condition resulting In death) **Examiner** The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. Heart Failure, Hypertension, Demenha Be Completed certificata has lirector, page 2 s Hospital or Attending Physician: 24 hours aftar daath. Puneral Director: Aftar this certifica etaly filled in by the funaral director, p 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) 2 1□ Yes 2⊡No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) Medical Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Critifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature end title of certifiar 29c. License number BC 5572195 APRIL 10,1998 HOUSE STAFF, MEDICINE Melack 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) GLENBURNIE BINU CHACKO, 301 HOSPITAL DRIVE 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State Ashia Davidson Rendell Registrar APR 21 1998

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death APRIL Arthur G. Zimmerman 12:10 AM 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth North Arundel Hospital Glen Burnie Anne Arundel 8. Data of Birth 9. Birthpiace Country)
Dec. 23, 1912 unknown If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) 1 🛣 M 2 🗆 F 214-10-1798 Yrs 85 Usuel Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 0denton 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2419 Windling Ridge Road 21113 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces UNKNOWN Race - American Indian, Bleck, White, atc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) White 16b. Kind of Business/Industry Post Office 18. Mother's Name (First, Middle, Maiden Sumeme) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20c. Location - City or Town, State ²² State Anatomy Board, 655 W. Baltimore Street 4 WEEKS

> 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings aveileble prior to completion of ceusa of death? 24e. Wes an eutopsy performed?

2 1 No 1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

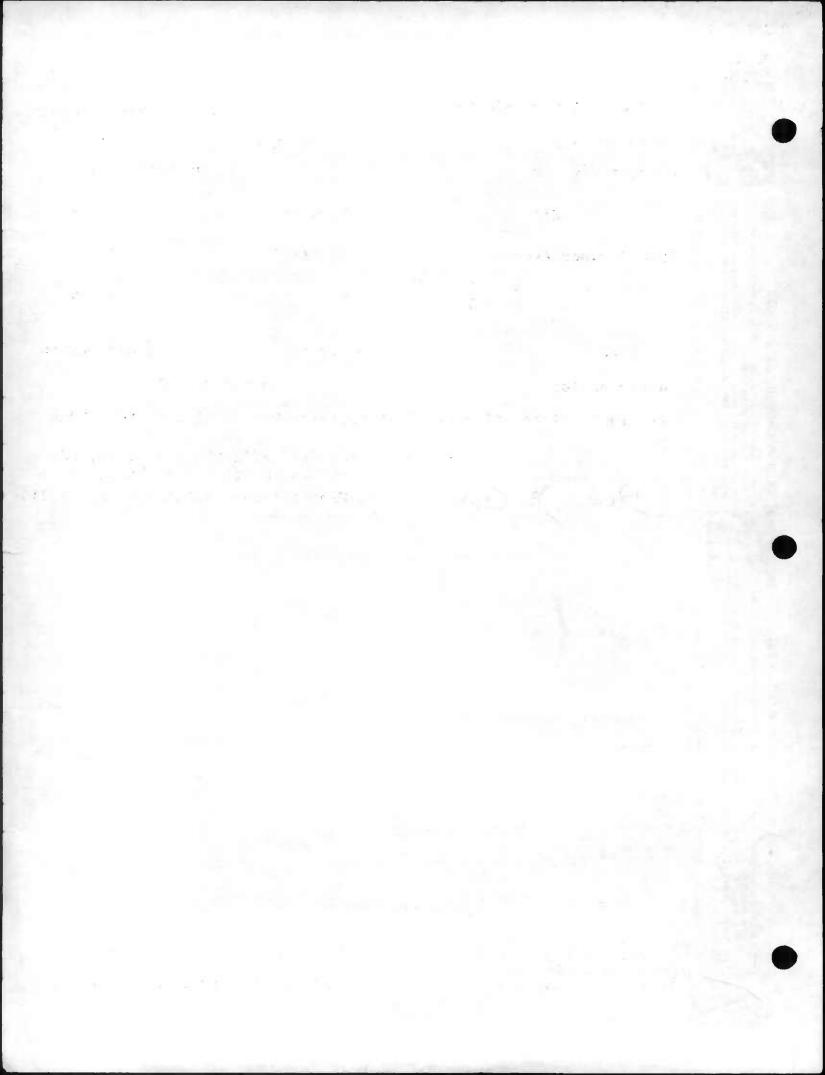
29d. Date signed (Month, Dey, Year)

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98-2141-510

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Deeth Month 3,1998 11:15 P.M **Physician** Joseph Bagrowski Sr. PCI /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Baltimore Franklin Square Hospital Center 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If U Rasedala If Under 1 Year If Under 24 Hrs. Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Hours M 20 F 70 Director 217-22-7743 2-24-28 Usual Residenca of Decadent death with the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No MD Director Baltimore Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8416 Allison Lane 21237 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? should be filed within 72 hours efter nd Mentel Hygiena. Yes 2 No fives, Give Year or Dates: 1 Nevar Married 2 Married Dagrows Ki, Joseph 1 ☐ Yes 2 ☑ No Specify: Specify: à WW II 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mechanical Engineer 12 Westinghouse 18. Mother's Name (First, Middle, Melden Surneme) 17. Father's Name (First, Middle, Last) Be Proper 1 and 2 should be in the property of Health end Mentel | Stephen Martin Bagrowski Rose Lipkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Holly Bagrowski/daughter 2047 Wintergreen Place, Baltimore, MD 27 20b. Placa of Disposition (Name of 20c. Location - City or Town, State Data 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Rosary 4-22-98 Baltimore, MD 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, 21237 23a. Part1. Enter the disease, or complication's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical -ncephalopathy Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine The lew requires thet the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequenca of): signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy Completed Is certificate has director, pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifian

04/19/98

9000 Franklin Square Dr Baltimore, MD2123

88813

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

ajah

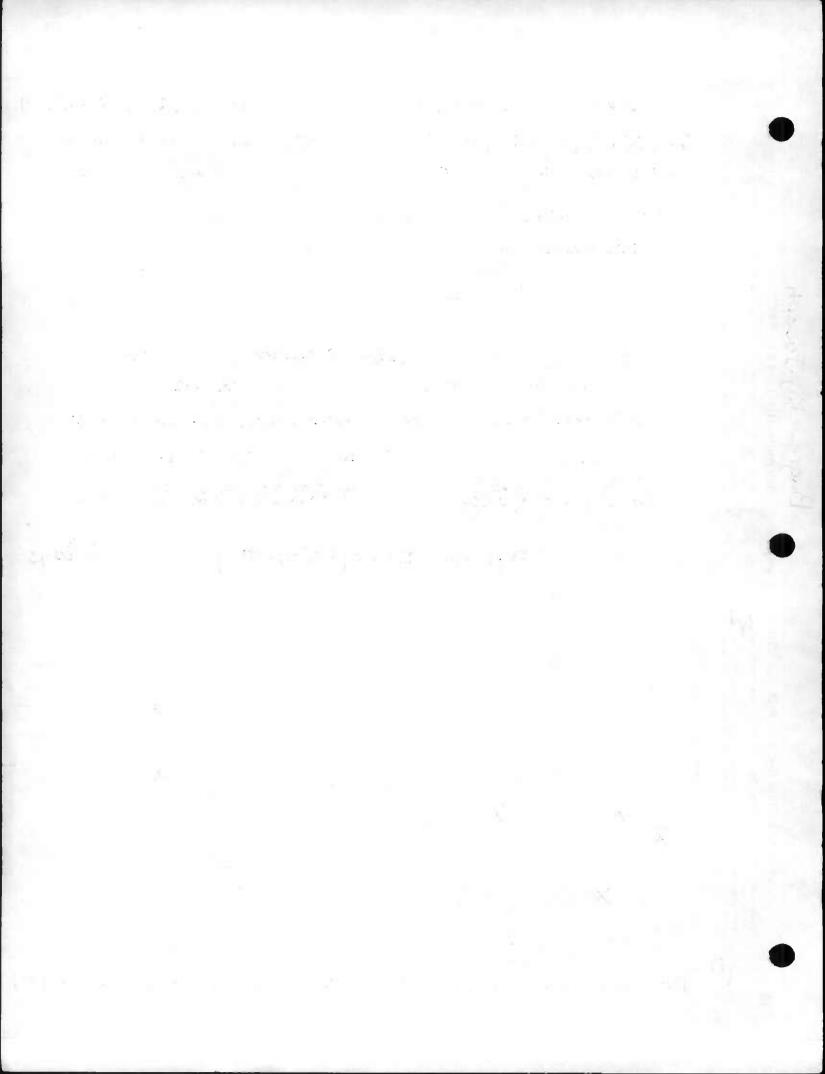
31. Date filed (Month, Day, Year)

Ragura's

Markey Bondall

Registrar

State



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Marie Evelyn Bergner 19, 1998 April 2:00 A.M. 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Anne Arundel General Hospital Annapolis Anne Arundel County If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2⊠ F Yrs 218-09-1739 Dec. 22, 1918 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Anne Arundel Annapolis 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 84 North Old Mill Bottom Road 21401 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 9th Grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meredith Clayton Jefferson Edith Byerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Bergner/Son 1604 Troys Court, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/21/98 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Gardens of Faith Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller, Inc. 21. Signatur of Funeral Servica Licensee uanita 6415 Belair Road, Baltimore, Maryland 21206 Homas nor the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, and tailure. List only one cause on each line. Immediate Cause (Final week disease or condition resulting in death) Due to (or es e consequence of): Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Duelo (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Iti Sufact Dementia 24b. Were autopsy tindings eveilable prior to 24e. Was en eutopsy performed? completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

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Funeral

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Department of
Important: If it
any Injury or

altimore, Maryland 21215-0020

Examiner physician end the barial-trensit Physician/Medical signed by t ģ Completed

page 2 certificate director. this funeral After

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or Attending Physician: efter death. 24 hours e Hospital completely

Division of Vital Records, P.O.

To the Within 2 State Registrar

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Mannenot Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier

12 Cartifying Phyalcian: To the best ot my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only one)

29d. Dete signed (Month, Day, Year)

answar MD

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

HAWMAN, 200 HARRY TRUMAN PKWY, ANNAMIN, MD. 21401

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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month April 20, 1998 **Physician** Louis Joseph Barber 9:30 P.M. /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore County 5217 Hazelwood Avenue Baltimore 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** MM 2DF Months Days Hours Min 215-14-9146 Yrs 75 Director Feb. 5, 1923 New Jersey Usual Residence of Decedent 10e State 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Maryland Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5217 Hazelwood Avenue 21206 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced 10/9/45. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4or 5+) Bar Owner 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) R. Michael ine Louis Barber Longo 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 5217 Hazelwood Avenue, Baltimore, Maryland 21206 Yolanda Barber/Wife 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 4/23/98 Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Pega Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility John C. Miller, Inc. thomas uanita 6415 Belair Road, Baltimore, Maryland 21206 Part 1. Eath, the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, hock, or high refailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** LUNG CARCINOMA WITH METASTASIS /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE Lung DISEASE P 24b. Were autopsy findings aveileble prior fo Completed 24e. Wes en autopsy completion of cause of death? 1 ☐ Yes 2 NHO 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 IN 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide ertifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and menner as stated. Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29c. License number

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29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0020

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State

Registrar

31. Date filed (Month, Day, Year) APR 2 2 1999

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29a. Certifier

29b. Signature

30. Name and a

dress of person who completed druse of deeth (Item 23a) (Type, Print)

HICADEPHER RS., BALTO. gegistrar's Signature Lawrence—Randelle

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:26 p. m 2207 Dri aymond 4a Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL NA HE BAltimore If Under 24 Hrs. 8. Hopkins Sohns If Under 1 Yea 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 6. Sex Months Days Min 1 MM 2□ F 49 Hours 220-46-NOVEMBER 27, 1948 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. inside City Limits 1 Yes 2 No ALTIMORE MARYLAND NIA 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? 2120 14. Reca - American Indian. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 M Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: PSLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH GRADE MAINTENANCE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) RAYMOND LROSS HELMA 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3619 FOREST GARDENAVE, BALTIMORE, MARYLAND 21209 (COUSIN) DORIS JONES 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4-22-98 12TRO CREMATORY 4 Donation 5 Other (Specify) 22. Nama and Address of Facility e of Funeral Service Licensee JUSEPH H. BROWN JR. FUNERAL HOME, P.A. 23a. Part1. Enter tha disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Finat disease or condition resulting in death) Pulmonary Embol Due to (or as a consequence of): Venous hrom bosi Due to (or as a consequence of) Hemor Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown abuse 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yas 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner**

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Certification:

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Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury attending physician Nor use as the burla Physician/Medical thet initiated events resulting in death) Last

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25. Was case referred to medicel

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5 Pending invastigation 2 Accident 3 Suicida 6 Could not be 4 Homicide

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28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of cartifier

29c. License number

1 Yes 2 No

29d. Date signed (Month, Dav. Year)

Resident Physician 30. Neme and eddress of person who completed cause of death (Item 26a) (Type, Print)

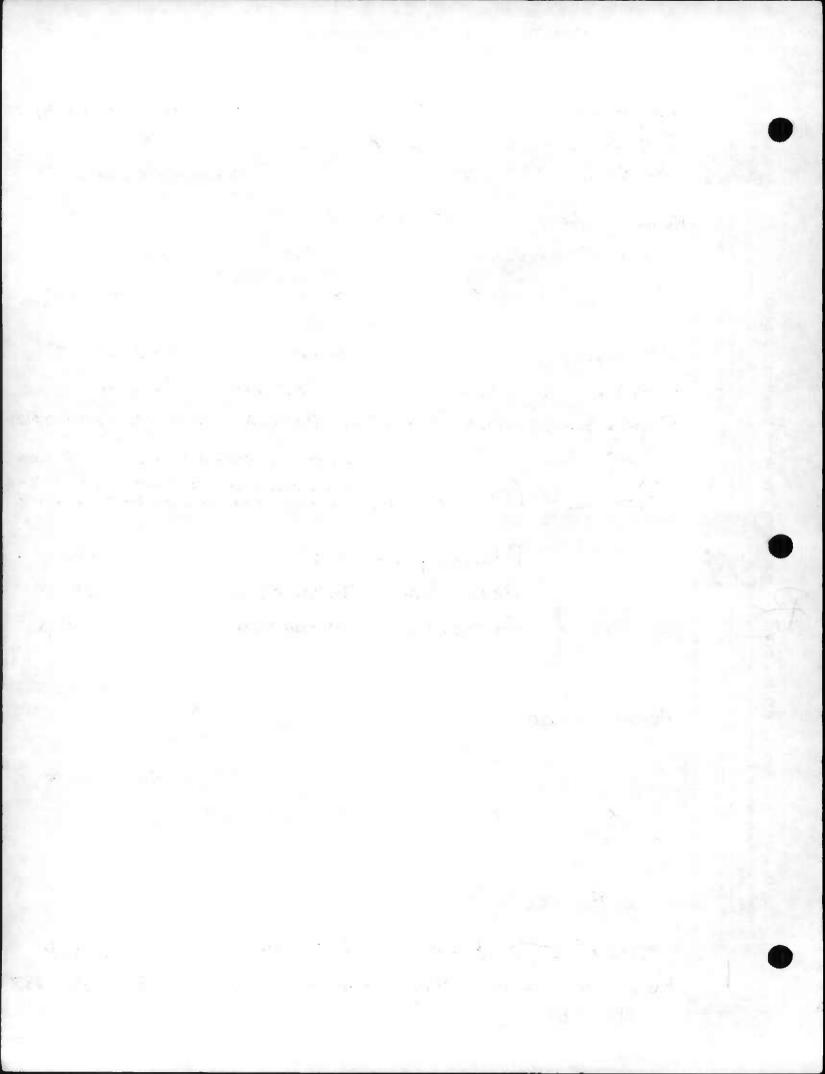
7-113, 600 N. Wolfe St. Baltimore, MD21287 Meyer

31. Date filed (Month, Day, Year)

APR 22 1998

32 Agaistra Signatura

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Month **Physician** VIRGINIA CROWTHER APRIL 6.50 AM 17 1998 /Medical 4e. Fecility Nama (If not Institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** - 800 SOUTHERLY KOAD EDEN WALA 10WSON BALTIMORE 5. Sociei Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthpiece (Stete or Foraign Country) **Funeral** 1□M 20€F Months Days Hours 214405652 89 Director VIRGÍNIA Usuel Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Menyland Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 800 SOUTHERLY ROAD Funeral 21284 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No ģ Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 6 TEACHER CITY SCHOOLS 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be L. PAYNE WILLIAM BI ANCH GAMMON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SUSAN P. HENNIGHAUSEN/DAUGHTER 2 ELKHART COURT BALTIMORE, MD 21237 20b. Pieca of Disposition (Neme of camatery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Buriel 2 Cramation 3 Removei from State 4 Donetion 5 Other (Specify) 4/20/98 TOWSON, MD DULANEY VALLEY 21. Signature of Eugeral Service Licensee 22. Name and Address of Fecility 1211 CHESACO AVE. CVACH/ROSEDALE FUNERAL HOME BALTO, MD 21237 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finei diseese or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted evants resulting in deeth) Last Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The lew requires that the death certificate be within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician. Physician/Medical Due to (or as a consequence of) Pert li. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings avelleble prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 1 Yes 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 1 Yes 2 No 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Neturei 2 Accident 5 Pending invastigation 1 Yas 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pieca of injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicide 29a. Certifier Csrtifying Physician: To the best of my knowledge, deeth occurred at the time, date end piace, and due to the cause(s) and manner as stated. Medical |edical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. 29b. Signature and title of certifie 29c. License number 30. Name and eddrass of person who completed cause of death (Item/23e) (Type, Print)

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32 Registrer's Signeture

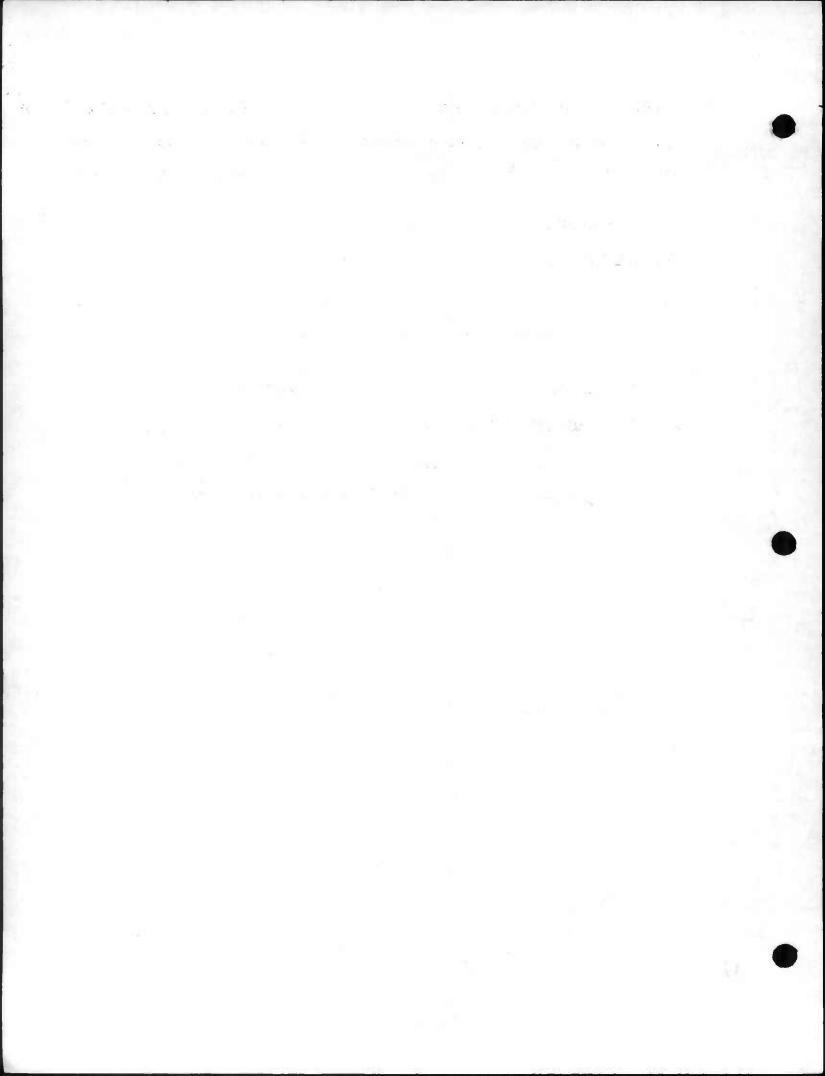
Julia Davidson

Registrar

State

31. Date filed (Month, Dey, Yeer)

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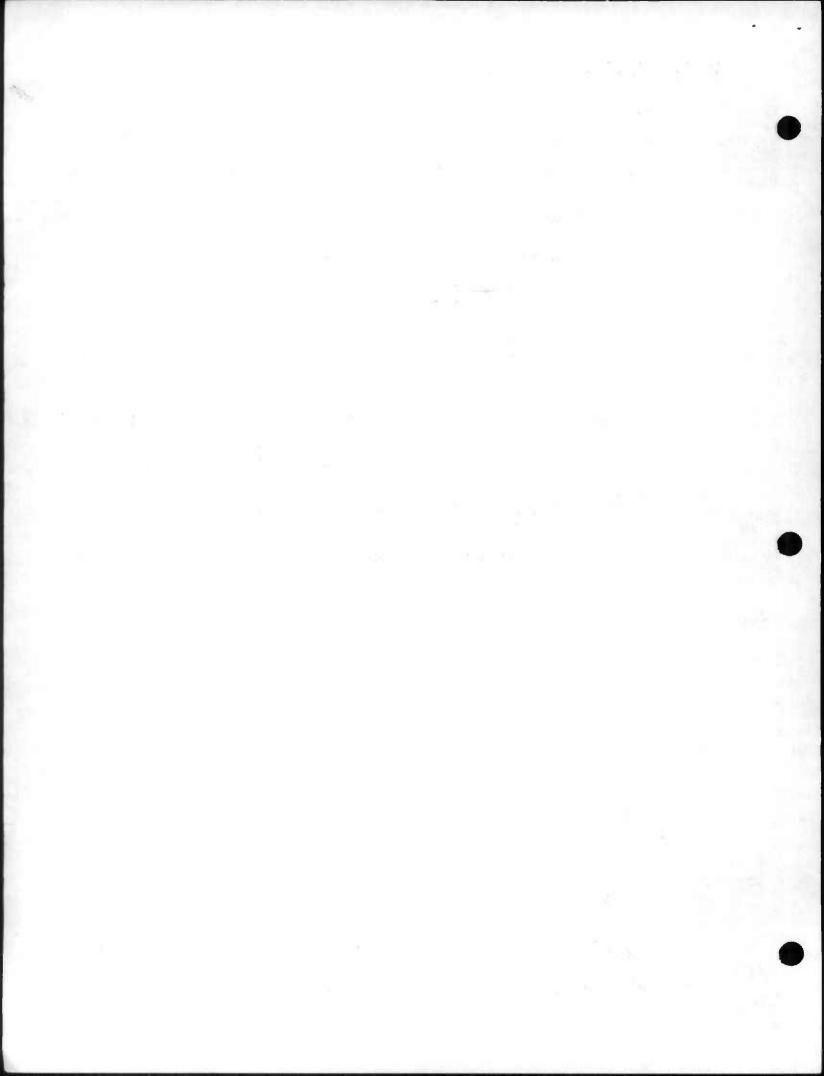
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DC 19655

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

JOHN MARSHALL 3800 Reservoir Rd. NW, Washington, DC 20007

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month **Physician** ar /Medical 4a. Fecility Nama (M.not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHN HOPKINS BAYVIEW MEDICAL CENTER N/A BALTIMORE 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Social Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 12/25/10 Birthpleca (Stata or Foraign Country)
 A B **Funeral** Days 1□ M 2∰F 87 Director 232 62 9446 VA. WEST Usual Rasidance of Dacedant 10e. Stata Hygiene. other than "naturel", or items 23e or 28e-f ehow ent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1⊞ Yas 2□ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5516 SEWARD AVE. 21206 USA Funerai Pages 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hyglene.

111: If Hear 27 Is marked other than "naturel", or itema 23 mry or other traumatic event, the Mental Exercise manny or other traumatic event, the Mental Exercise manny. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∰ No If Yas, Giva ″ Yeer or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 # No Specify: Specify: AFRO AMERICAN Completed by 3 ∰ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) Collaga (1-4or 5+) Elementery/Secondary (0-12) HOMEMAKER HOME 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be CHARLIE MAYO CARRIE MAYO 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) **BOOKER ANDERSON** 5516 SEWARD AVE. BALTO. MD. 21206 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Department of Important: if any injury or once. BALTIMORE CEMETERY 4/21/98 BALTIMORE, CITY 21. Signatura of Fungral Service Licensaa 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME PA 1300 EUTAW PL. BALTO. MD. 23a. Part1. Enter the disaasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last The law requires that the death certificate be execu P.O. Box 68760. Physician/Medicai Part II. Other significant conditions contributing to death but 23b. Did tobacco use contribute to the cause of death? not resulting in the underlying cause given in Pert I. 2□ No 3 Probably 4 Unknown Division of Vital Records. Be Completed by page 2 should be 24b. Wara autopsy findings available prior to completion of cause of deeth? 24e. Was an eutopsy performed? 20 No After death.

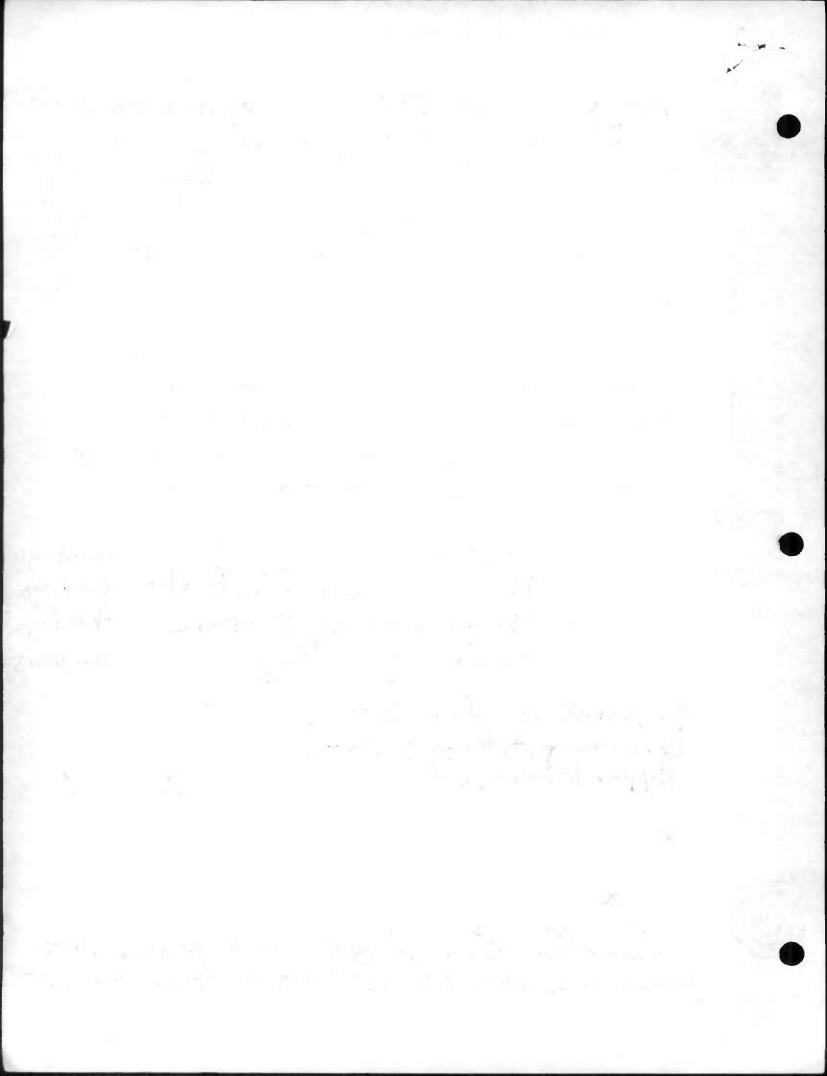
Director: After this certifice 25. Was care referred to madical 26. Placa of Daath (Check only ona) Hospital: 15 Inpatient 2 ER/Outpatiant 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascriba how injury occurred 5 Panding Invastigation 1 Natural 2 Accidant 1 ☐ Yas 2 ☐ No 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) B 4 Homicida 29a. Certifian Certifying Phyaiclen: To the best of my knowladga, death occurred at tha tima, data and place, and dua to the cause(s) end menner es stated. Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and mennar stated. 29b. Signature and title of certifi 29c. Licansa number 29d. Dete signed (Month, Day, Year) 30. Nama and address of parson who complate causa of death (Itam V. My Johns Hopkils Donald A. Dibbern;

State Registrar 31. Deta filed (Month, Day, Yaar)

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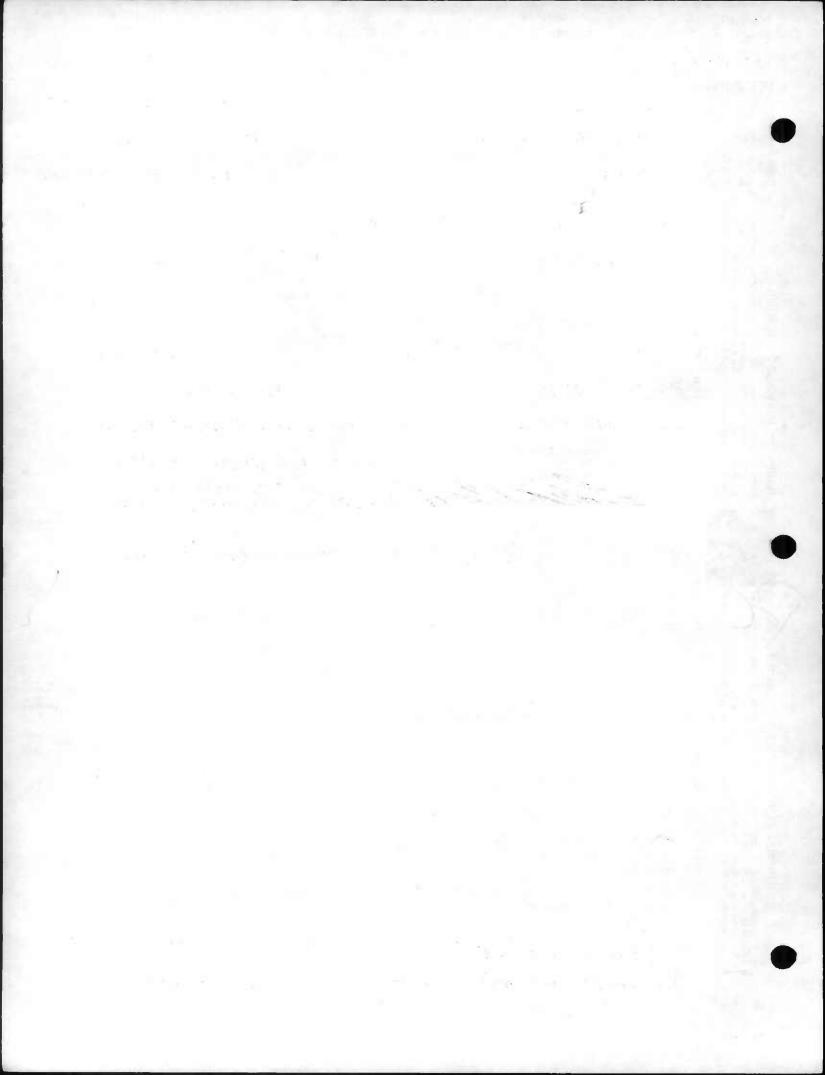


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8a-f per MEO G-759 Certificate of Death Reg. No. MARK DANIELS Items: 23 part I,II,27,28a-f per MEO G-759 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death APRIL **Physician** 14 1998 11:35 AM MARK DANIELS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** CHURCH HOME HOSPITAL E.R. BALTIMORE N/A If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours UM 2DF 38 Yrs. 167-46-6215 Director Aug. 13, 1959 PENNSYLVANIA Usual Residence of Decedent the Merylend 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "neturel", or items 23s or 28s-f show the Medical Examines, must be notified at 1 Yes 2 □ No Pa. Director N/APhiladelphia 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? filed within 72 hours after death with the Hygiena. Funeral 4330 Lawndale Street 19124 I.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Bieck, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. by 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Peges 1 and 2 should be nant of Haalth and Mantal WALTER DANIELS MARION BENNEMAN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit, Peges 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum pnce. WALTER DANIELS/FATHER 4330 LAWNDALE STREET, PHILADEL PHIA, PA. 19124 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BENSALEM, PA. RESSURECTION CEMETERY 4/18/98 21. Signature of Funeral Seguine Name and Address of Fecility TLLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Death VENLAFAXINE INTOXICATION **Physician** /Medical Immediate Cause (Final no) wend disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical The law requires that the death cartificate Due to (or es a consequence of) ed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE signed t b 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an eutopsy s cartificete hes t 10 Yes 2□ No 2 No diractor, Hospital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 XX Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Date of Injury (Month, Day Year) Certification: 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Aftar 5 Pending Investigation Vatural daath. 1 TYes 2 No 4/14/98 Unknown Subject ingested drugs ofter daath Director: A 2 Accident XX Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 402 S. Bond St. 4 ☐ Homicide in 24 hours ene the Funeral Dir nplately filled in Building Baltimore, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check or one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number APRIL 15, 1998 O.C.M.E ddress of person who completed cause of deeth (Item 23e) (Type, Print) MC 111 Penn Street, Baltimore, Maryland 21201 LUC 32. Registr s Signalara State who Davidson Randall

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

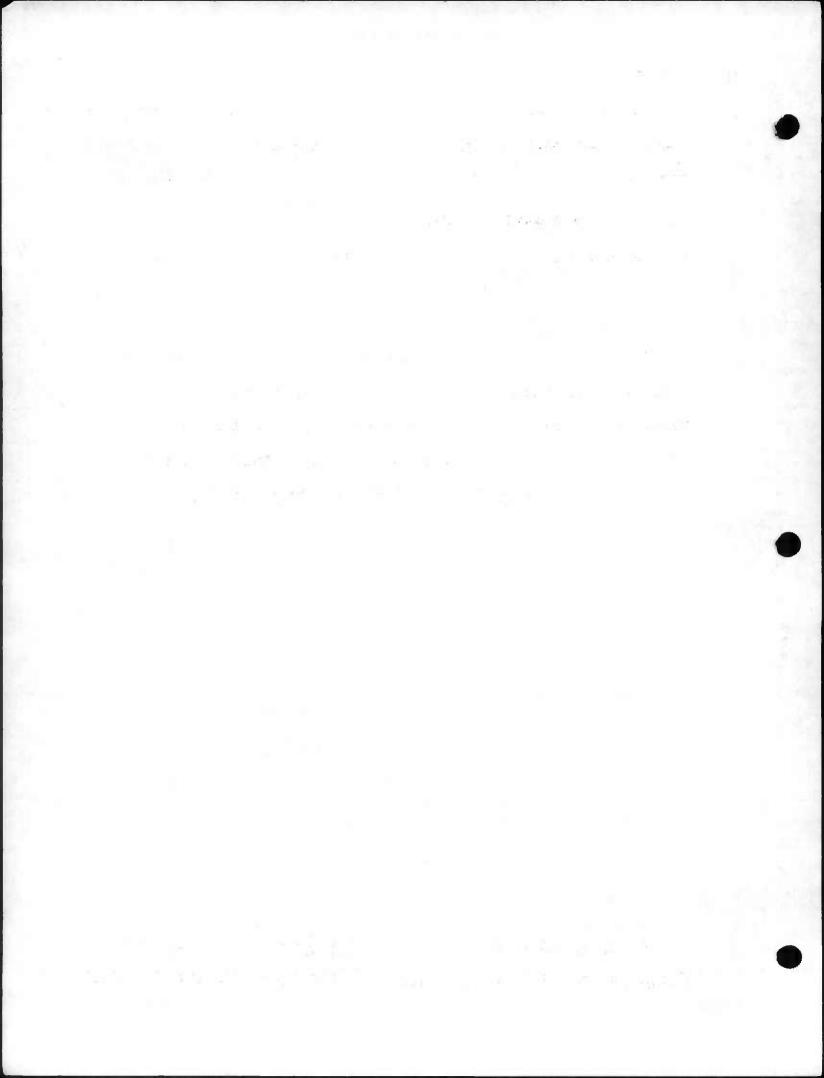
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death DOBRO WOLSKY. Month **Physician** MYRON, 9:45 AM 1998 APRIL 17 3 /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard County 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months 12M 2□F 216-32-4889 70 Yrs Ukraine Director Usuet Rasidance of Dacadant permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a4 show any Injury or other traumatic event, the Medical Experiment must be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida Ctty Limita aryland Howard County Ellicott City 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citlzan of What Country? 2873 Evergreen Way 21042 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Tyas 2 No If Yes, Giva Year or Datas: Korea 1 ☐ Naver Married 2 Married Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Bustnass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ pharmacist pharmacy 17. Fethar's Name (First, Middla, Last) 18. Mothar'a Nama (First, Middle, Maidan Sumama) Basil Dobrowolsky Maria Cobniw 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Ms. Maria Dobrowolsky/spouse 2873 Evergreen Way, Ellicott City, MD 21042 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) John's Cemetery 21APR98 Ellicott City, MD 21. Signatura of Funaral Sarvice Licansee 22. Name end Address of Fecility Slack Funeral Some, P.A. Part . Enter the diseasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician fmmediata Causa (Final disease or condition rasulting In daath) /Medical Examiner Due to (or as a consequenca of Examiner CARDIOMYO PATHU Dua to (or as a consequance of): Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Cause (Disaese or Injury that Initiated avants rasulting in daath) Last burial-t physician sthe burial MYOCARDIAL IMPARELION Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consaquance of): CANCLER Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? SEVERE ANEMIA 1 Yes 2 No 3 No Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Wes case refarrad to medical axaminer? funeral director, Be 26. Plece of Death (Chack only ona) Hospitel: 1 ☐ Inpatiant 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 1 ☐ Yes 2 No 28e. Date of Injury (Month, Day Yaer) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 2 Accidant 1 Yas 2 No 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 - Homicide Certifying Phyeician: To tha best of my knowledge, daeth occurred at tha time, data and place, end due to the cause(s) end menner es steted.

Medicat Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and mannar statad. 29a. Cartifian Medical 29b. Signatura and title of certifian 29c. Ltcansa number 29d. Data stgned (Month, Day, Year) 30. Nema and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 028921 CHOUPHRY 10 792 HICKORY PAIRE ROOM COVEMBLA
32. Raginglething Mindson Rounde M1210 LL 31. Data filed (Month AD) (New 2) 2 1998 State

Registrar

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_	28		30 Name and eddress of person who c	Seloni	CU, U	U.D.	rint) 90	O Bestga	HE AUU	napolis	, Me	d. 21401		
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registre	er Signatur	Millann.	Tando 20							



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Nama (First Middle Last) 2. Data of Death 3. Tima of Deeth April 21, Day 998 **Physician** Vita E. 1:00am /Medical 4a Facility Nama (If not institution, give street and number)
Augsburg Lutheran Home 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Baltimore Baltimore Birthplaca (Stete or Foreign Country) If Undar 24 Hrs. If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 M 2 XF Months Hours Min. Yrs. May 2, 1913 Director Wisconsin 215-12-9389 Usual Rasidance of Decedan with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ahow 7 is marked other than "naturel", or itema 23a or 28a-f ahov traumatic event, tra Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Anne Arundel Edgewater 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 444 Poplar Leaf Drive 21037 USA B death Funer 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, 11. Maritai Status Black, Whita, atc. filed within 72 hours after 1 Navar Marriad 2 Married White 1 ☐ Yes 2 No Specify: Specify by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b, Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collaga (1-4or 5+) 12 Registered Nurse Nursing nit. Pages 1 and 2 should be filed narriment of Health and Mantal Hygin ortant: If them 27 is marked other injury or other traumatic event, It 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Edward Engelbert Clara Gruen 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Karen Dunn - Daughter-in-law 444 Poplar Leaf Drive, Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Locetion - City or Town, Stata 1 ☐ Burial 2 IX Cramation 3 ☐ Ramoval from State Department of Important: If any injury or once. Metro Crematory 4/22 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD of antar the mode of dying, such as cerdiac or respiratory errest, 21401 ns that causad tha death. Party. Entar tha disaasa, or complications that causad th shock, or haarl failura. List only ona causa on each lina. Approximete Intarval Batwaen Onsat and Death Physician immediata Causa (Final disaase or condition rasulting in daath) /Medical END STAGE ALZHEIMER DEMENTIA MONTH **Examiner** Due to (or as a consequanca of): Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last Due to (or as a consaquanca of): Physician/Medical Dua to (or as a consaguance of): 88 080 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performad?

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State Registrar

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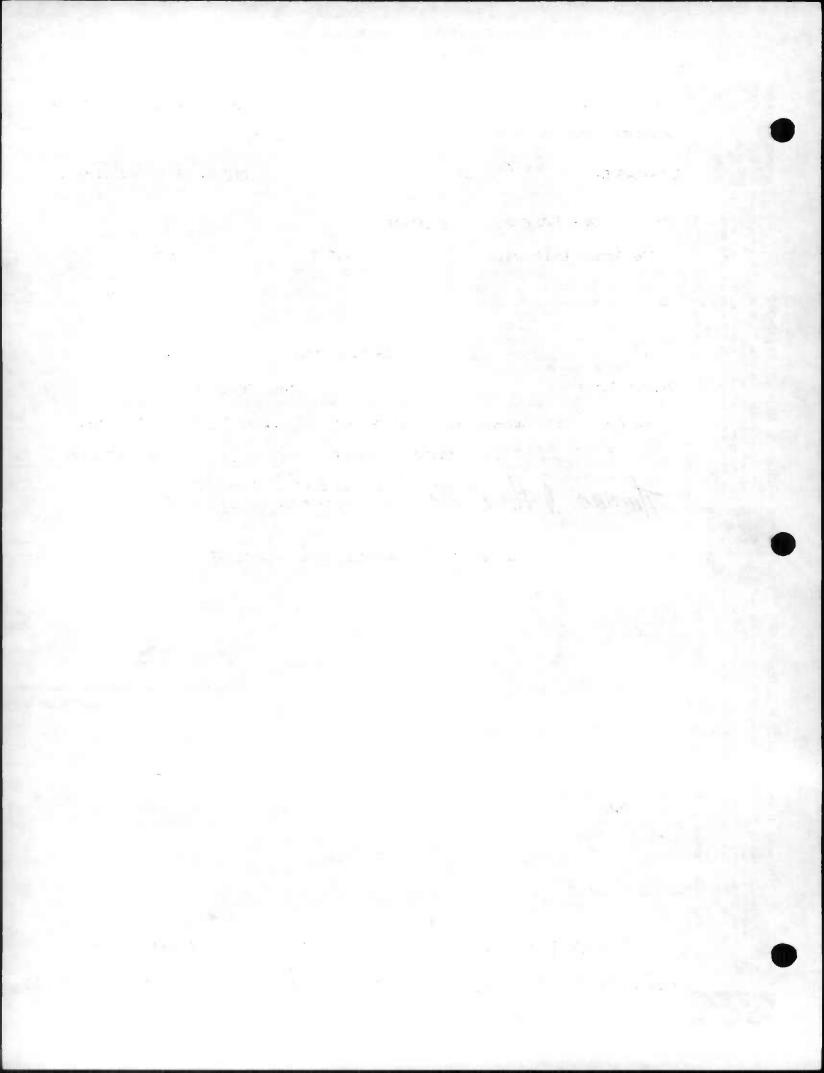
> 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha causa(s) end mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29c. Licansa number

29b. Signatura and titla of certifiar

29d. Data signed (Month, Day, Year)

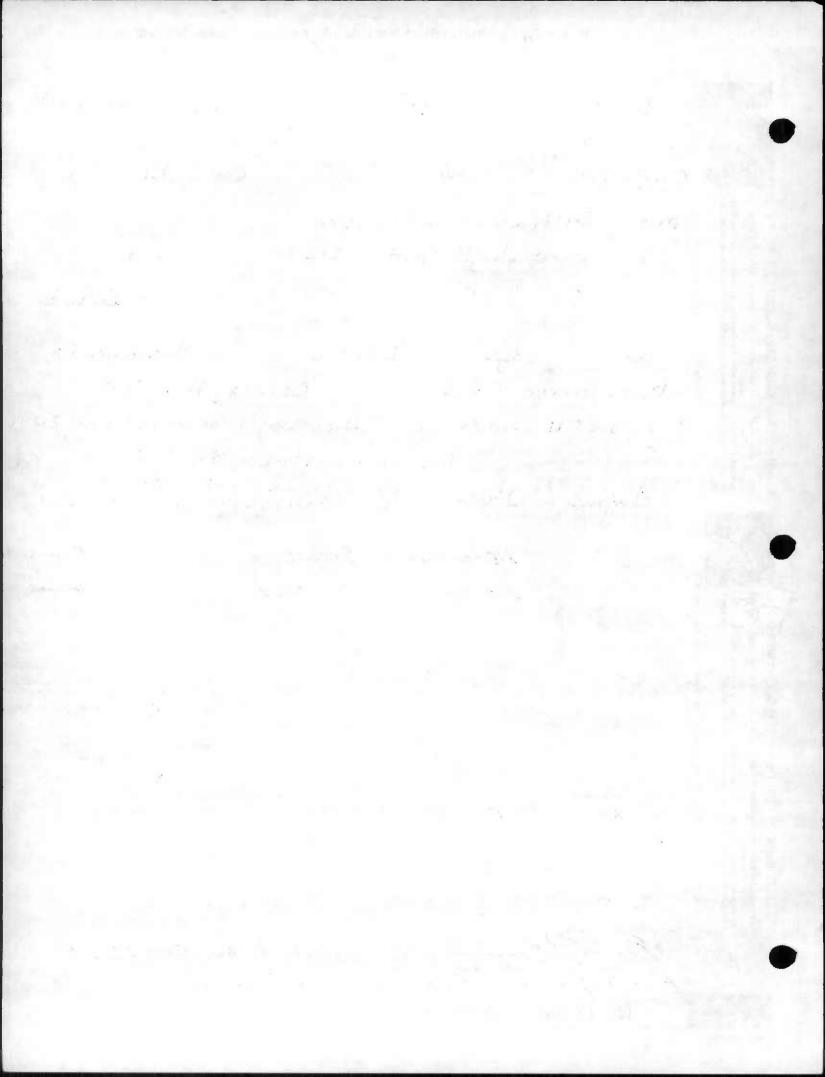
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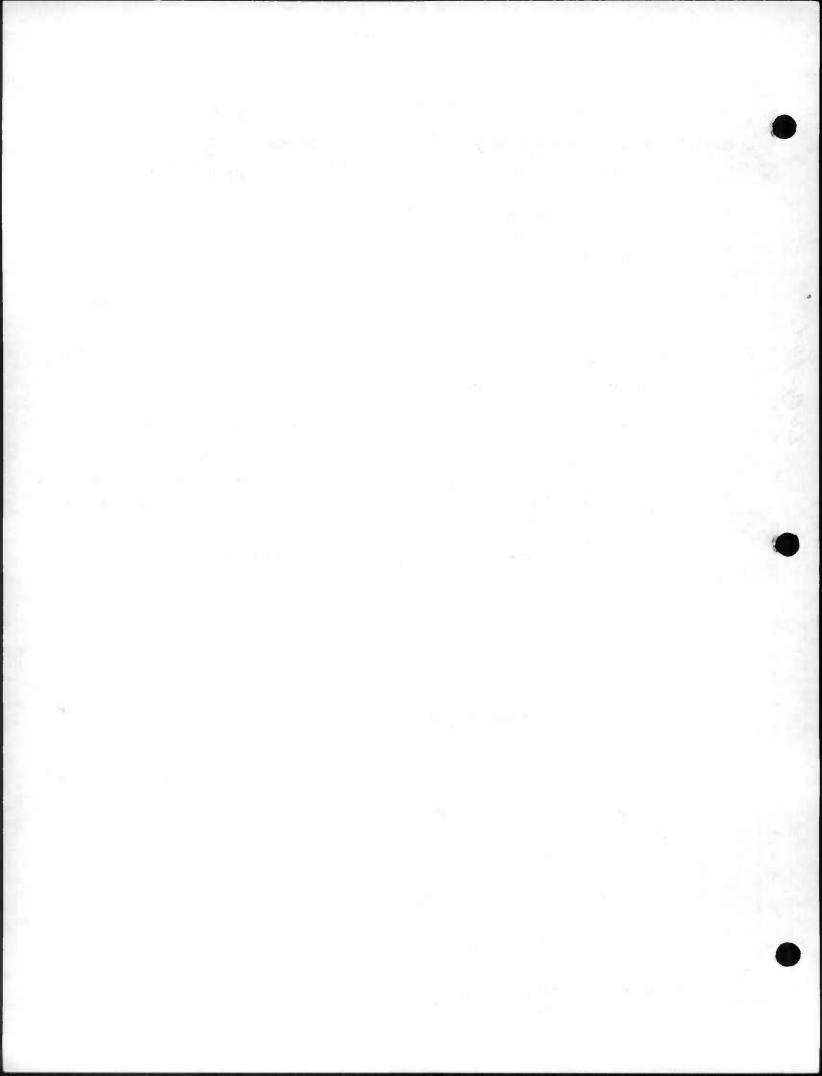
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State of Maryland / Department of Health and Mental Hygiene 🔾 🎗

Certificate of Death A Month 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Ford Lucy 6 /Medical 4e. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore City
If Under 1 Year If Under 24 Hrs. 8. Data of Bi General Hospital laryland Data of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Birthplece (Stete or Foreign Country) Deys 1 □ M 200 F 212-32-3374 101 Yrs. Director 5-1897 VA Usuel Residence of Decedent death with the Maryland 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be not the death and Injury or other traumatic event, the Medical Examinat must be not the death and Injury or other traumatic event, the Medical Examinat must be not the death and Injury or other traumatic event. Md. NA Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1040 N. Luzerne Avenue 21205 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Bieck, White, atc. 1 Never Married 2 □ Married 1 ☐ Yes 🏖 🛣 No If Yes, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3€Widowed 4 □ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 4th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Edward J. Jennings Rosa В. Jennings 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 1040 N. Luzerne Avenue Baltimore, Md. Lawrence Jennings 20b. Piace of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stata Cem. 04-23-98 Arbutus, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Mem. Pk. 21. Signeture of Funeral Service Licensae 22. Neme end Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlec or respiretory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Intervel Between Onsel end Deeth **Physician** Atheroseleratie Cardiovascular Disease Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Due to (or as a consequence of) Pert II. Other algnificant conditiona contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Cerebrovascular Accident; Dementia signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? After this certificate has 1 ☐ Yes 2 12 No 1 ☐ Yes 2 No 25. Was cese referred to medicel 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yas 2 No nours after death.

neral Director: After this y filled in by the funeral di 28e. Dete of Injury (Month, Day Year) 27. Manger of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 Neturel 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, ferm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homleide 24 hours 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. 29a. Certifier To the Hospi within 24 hou To the Funer completely fill Medicai 29b. Signature and title of certifiar 29c. Licansa numbar 29d. Data signed (Month, Dey, Year) MO 30 Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Salu Maryland General Hospital State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Physician EILEGN 2:14 Am ROPIT 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Daath **Examiner** BAWIEW HOPKINS BALTIMORE JUINS If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 V Yrs Director 217-16-6251 Feb. 23,1924 Maryland Usuel Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? Funeral 8202 Cornwall Road 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours aftar or and of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or iten iny or other traumatic event, the Medical Experimenty or other traumatic event, the Medical Experiments 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Years Own Home Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ethel Florence Ritter Charles Edward LeDoven 19a. Informent's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland Mr. Charles R. Fort, Sr. 8202 Cornwall Road 20b. Placa of Disposition (Name of cametery, crematory or other place)
Gardens of Faith Cem. 4/23/98 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Baltimore, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland least, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, a tonity one cause on each line. Approximate Interval Betwe Onsat and Death **Physician** /Medical Immadiate Cause (Final disaase or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last P.O. Box 68760, Physician/Medical The lew requires that the death cartificated the Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? lar disease 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yas 2 No certificate Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical exeminer? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 12 Inpatient Certification: To 1 Yes 2 ER/Outpetient 3 DOA this 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigetion 2 Accident in by tha 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli 29a. Certifier 15 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. Medicai complately To the 29b. Signature and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) MD. HOUSE STAFF 96007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL HALEVY, MD 4940 EASTERN AVE, BALTIMORE, NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar -na Nevidson-Abordale

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) April 20, 1998 Robert Morton Fox 0047 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) ₩ 2 F 219-28-1707 64 Yrs. Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Anne Arundel Annapolis 12 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Decatur Avenue 21403 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S. Armed Forces? 1 ★Yes 2 → No If Yes, Give 1955-58 Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 21 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor College/Education 5+ 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Robert Lee Fox Selma Fiteman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Susan M. Fox - Wife 22 Decatur Avenue, Annapolis, MD 20b. Place of Disposition (Name of cametery, crematory or other placa) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from State Lakemont Cemetery 4/23 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Fecility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licens 12 Ridgely Ave. Annapolis, MD 21401 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. 23a. Pert1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Onset and Death Immediete Cause (Finel disease or condition resulting in deeth) Live failure Due to (or as a consequence of): 2 Weeken Alcoholism Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760. signed & Division of Vital Records, page 2 has certificate the Hospital or Attending Physician:

Physician

/Medical

Examiner

Examiner Physician/Medical

Physician

/Medical

Examiner

Directo

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Baltimore, Maryland 21215-0020

by Completed 86 Certification: To

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After this funeral efter death. filled in by 24 hours

within 2 Registrar

JAMIE HARMS

4 Homicide

(Check only one)

29b. Signeture end title of certifier

29a. Certifler

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) MYTHAN IPSICAN BONLAR SHAR 32. Fedstar's Sanature Nandell

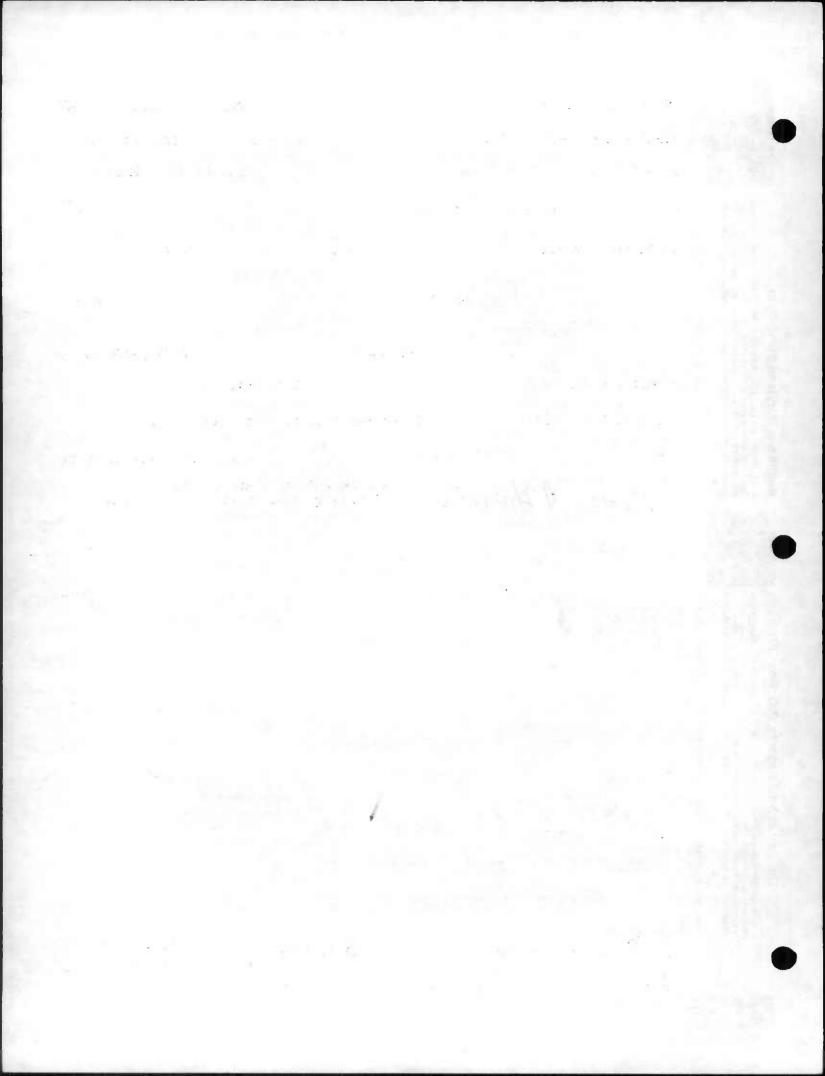
LE Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year) 4-23-58

FRANKLIN - CATHEORAL STREETS ANNAPOLIS, MO 21401



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) APRIL 16,1998 23:24 FINN 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year If Under 24 Hrs. JAN. 13, 1929 9. Birthplace (State or Foraign 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 M F PENNSYLVANIA Yrs. 69 Usuel Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits MONTGOMERY ROCKVILLE 1 ☐ Yes 2 DieNo 10f. Zip Code 10g. Citizen of Whet Country? UNITED STATES 20853 4404 CHERRY VALLEY DRIVE 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) CHOMYAK SLAVIK 19b. Mailing Address (Streat and Numbar or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 4404 CHERRY VALLEY DRIVE, ROCKVILLE, MD. 20853 WILLIAM DONALD FINN, HUSBAND 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4/21/98 SILVER SPRING, MD. GATE OF HEAVEN CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses MURNIFOLONG HOME BARBER FUNERAL HOME 21-1 P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona cause on each line. Approximete Intervel Between Onset and Deeth 4GANS CHRONIC RENAL PAILURE Due to (or es a consequenca of): years DIAGERES MELLIOZIS Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Med cal Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mantal Hygiana. Important: if item 27 is marked other than "natural; or items 23a any Injury or other traumatic event, the Med call Examinet matal once.

Saltimore, Maryland 21215-0020

with the Maryland

MARTHA

5. Sociel Security Number

10e. Street end Number

MICHAEL

20e. Method of Disposition

mure

10a. Stete

MD.

Director

Funeral

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Completed

183 24 0925

Examiner ician end buriel-transit physician s the burie Physician/Medical 50 950 þ Completed Be P funeral Certification:

immediate Cause (Finel diseese or condition rasulting in daath) Sequantially list conditions, if eny, leeding to Immediate cause. Enter Underlying Causa (Disaasa or Injury thet initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. PERIPHENAL VASCULAL DISEASE 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case raferred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred 28e. Data of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending 1 Natural 1 Yas 2 No investigation 2 Accidant 6 Could not be datarmined 3 Suicida 28e. Placa of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the causa(s) end mennar statad. 29e. Certifier (Check only one)

the death certificate be executed Box 68760 P.O. the signed by t Division of Vital Records, certificata has or Attending Physician: after death. Director: After this certifica

Hospital of 24 hours at Euneral D

To the I

29b. Signature end title of certifier

Deel M.D.

29c. License number D19192 29d. Dete signed (Month, Dey, Year) April 17, 1998

30. Neme end eddress of person who complated cause of deeth (Itam 23e) (Type, Print)

3941 FERRARA DRIVE WHEATON, MARYLAND 20906 BARRY HECHT, M.D.

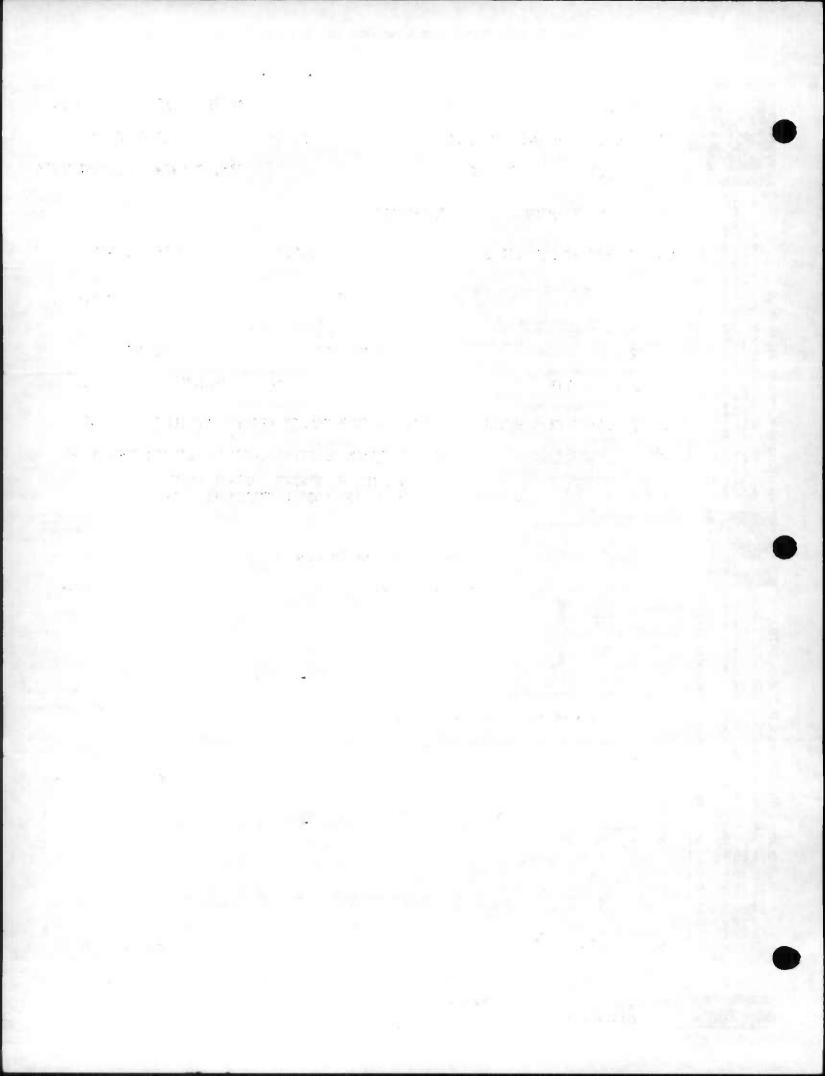
State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 2 2 1998





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State of Maryland / Department of Health and Mental Hygiene Q 2634 Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Daalh 3. Time of Death Month **Physician** Year 12:55pm Roland Howard Ferguson 18 1998 April /Medical 4a. Fecility Nema (if not institution, giva street end number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Fairhaven Life Care Community 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 6 Say Birthplece (Stete or Foraign Country) 6. Date of Birth (Month, Day, Year) **Funeral** 1√2 M 2□ F Months Days Hours California 197-34-9648 90 Yrs. Director Jan. 8, 1908 Usuel Residance of Decedant the Maryland 10c. City, Town or Location Sykesville 10a Stete 10b Counts 10d. Inside City Limits 7 is marked other than "natural", or Nems 23s or 28s-f ahow traumstic event, the Medical Examiner must be notified at MD Carroll Director 1 ☐ Yes 2/CXNo 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? USA 21784 7200 Third Avenue Funeral death 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Bleck, Whita, alc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 Is merked other than "natural", or ites any injury or other traumatic event, tra Med cal Examinat 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dalas: 1 ☐ Navar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Nidowad 4 Divorced Completed 15. Decedent's Education (Specify only highast greda complatad) 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. Forestry Service 4 Forester 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Robert H. Ferguson Louella Crawford 0 19a. Informent's Neme/Raletionship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6677 Mid Summer Night Ct. Sykesville MD 21784 Lawrence Ferguson (son) 20b. Pleca of Disposition (Nema of cametery, cremetory or other place)
Carroll Cremation Servc. 4/20/98 Hampstead MD 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 X Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Haight Funeral Home 21. Signatura of Funerel Service Licensaa · Way P.O. Box 195 Sykesville MD 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiretory errast, shock, or heer feitura. List only one ceuse on aech line. Approximeta nterval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Metastatic liver disease month disaase or condition resulting in daath) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to Immediate causa. Enter Underlying Cause (Diseese or Injury that Initiated evants resulting in death) Last physician and Due to (or as e consequence of): P.O. Box 68760. The law requires that the death certificate-be Physician/Medical Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? á 1 ☐ Yss 2 No 3 Probably 4 Unknown Atrial Fibrillation signed t Records, þ 24b. Were autopsy findings eveilabla prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: Tis after death.

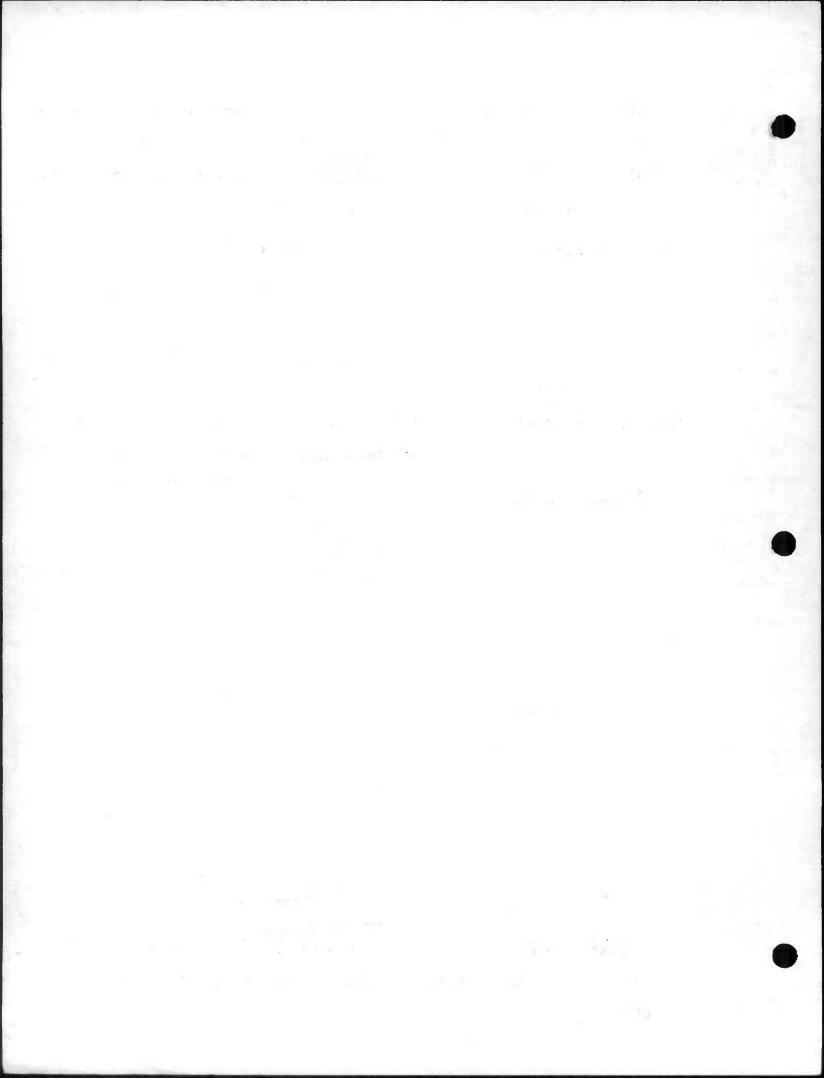
I Director: After this certificated in by the funeral director, po 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2₽No Certification: To 1 Inpatient 2 ER/OutpetienI 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending Invastigation 1 Nelurel 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the causa(s) and manner as steted.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner steted. 29a. Certifier Medical 29b. Signatura and litie of penifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) April 18, 1998 30. Name and eddress of person who complated cause of deeth (Item 23a) (Type, Print)
William Tan, MD 1645 Liberty Road Eldersburg MD 21784

State Registrar 31. Dete filed (Month, Dey, Year)

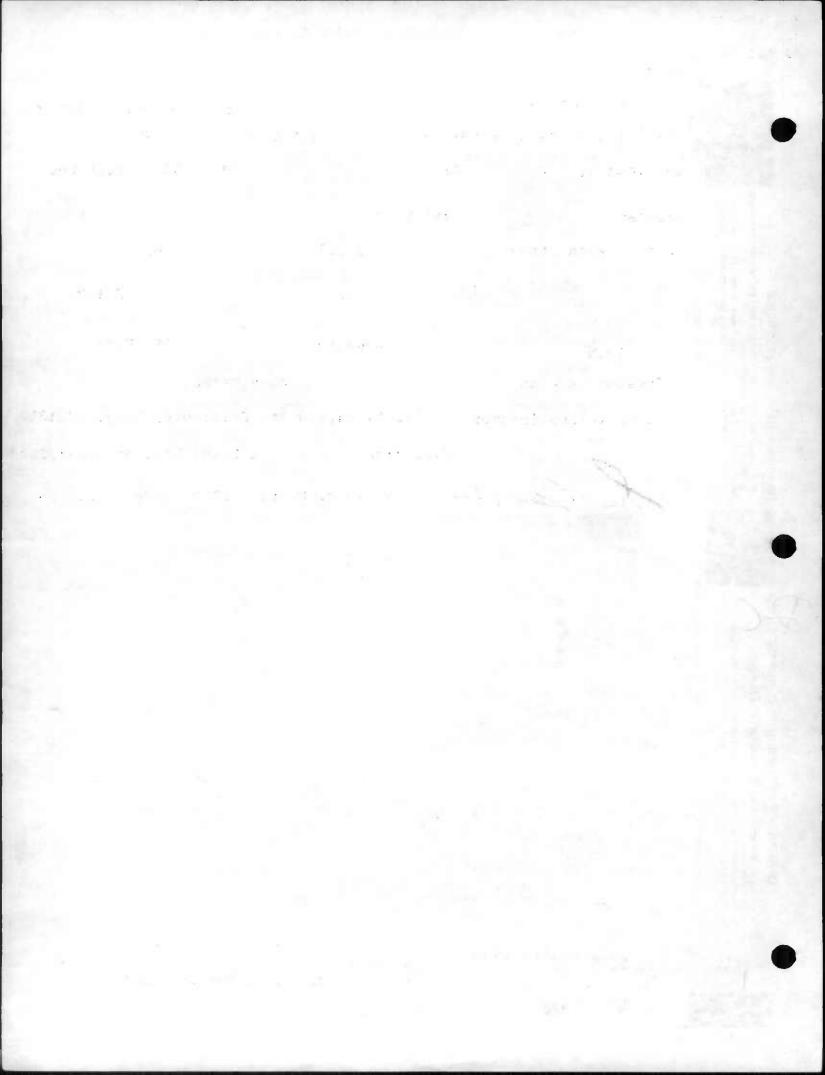
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Fire William Handell



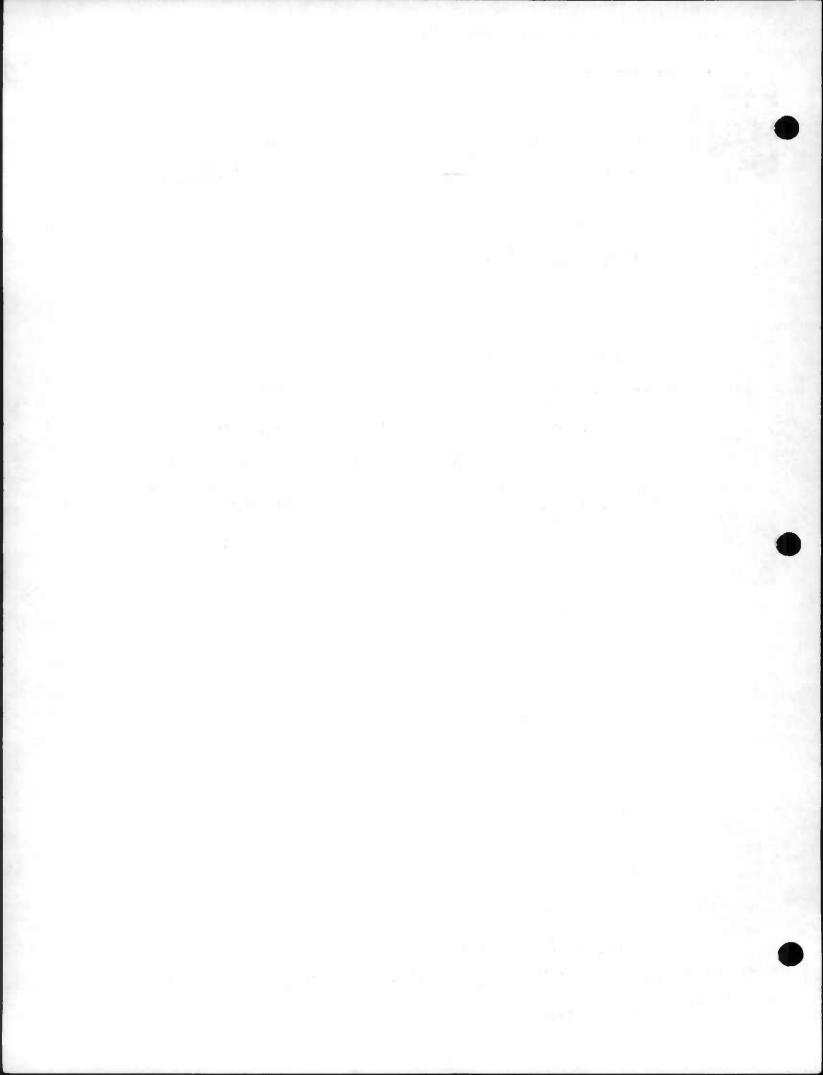
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RICE GAIN	ES	Items: 23 part I,II,2	State of No.						nd M		giene 9	3 1	2635		
Physicia /Medica		1. Decedent's Name (First, Middle, La Maurice Gair								2. Dete of Dee Month	2. Dete of Deeth Month Dey Yeer APRIL 17, 1998		3. Time of Death 0250 AM		
Examine		4a Fecility Name (If not institution, give street and number) 4b. City, Town, or U MERCY MEDICAL CENTER-EMERGENCY ROOM BALTIMOR													
Funeral Director		5. Social Security Number 227-76-4681 Usuel Residence of Decedent	Sex 7. A	47		rs. If Unde Months	Deys	If Under 24 Hours	Min.	8. Dete of Birth (Month, Day 10 1	v. Year) 50	9. Birthpl Count Mar	lece (Stete or Foreign try) Yland		
Maryland and ahow	tor												0d. Inside City Limits X□ Yes 2 □ No		
h with the 13a or 284	₽Ø	10e. Street end Number 12 N. Payson S	treet			10f. Zip Code 21217					10g. Citizen of Whet Country? U.S.				
urs a	by Funeral	11. Maritel Stetus 1 XX Never Married 2 Married 3 Widowed 4 Divorced	nt Ever in U 3? ₹No ::	No 3F				Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)			o- 14. Rece - American Indien, Black, White, etc. Specify: Black				
C	Completed	15. Decedant's E (Specify only highest gra Elamantary/Secondary (0-12) 12th	r 5+)	16e. Decedent's Usual Occupetion (Give kind of work dona during most of workil life. DO NOT use retired) Mechanic					16b. Kind of Businass/Industry Car Repair						
tal H d oth	To Be C									a (First, Middle, Melden Sumeme) Gaines					
and 2 should ealth and Men n 27 is merks her traumetic		19a. Informant's Name/Relationship (Helen Tolson			81	2 N. I	ays					Maryl	and21217		
Pages 1 nent of Ho ant: If iten uny or oth		20a. Method of Disposition 1X Buriei 2 □ Cremetion 3 □ 4 □ Donation Subther (Specification of the control of	Removal from State M		Place of Disposition (Neme of cemetery, cremetory or other ple . T . Zion			(1 -		Date -22-98	20c. Location - City or Town, State Baltimore, Mary				
permit. Departimontal		21. Signature of the ral Service Licensee 22. Name and Address of Facility Irvin P. Carrol							011	1 1712 W. North Avenue					
Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting In death) SEIZURE DISORDER ASSOCIATED WITH CHRONIC ALCOHOLISM Due to (or es a consequence of):											Intarval Between Onset end Deeth		
th the the the the the the the the the t	n/Medicai Examiner	Cause (Disease or Injury that initiated events the initiated events Due to (or es e consequence of):													
the d achec	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ORGANIC BRAIN SYNDROME											o the cause of death'		
	Completed by	CIRRHOSIS								performed? available prid			ere autopsy findings ailable prior to mpletion of cause		
	е Сошр	DEMENTIA 25. Was case raferred to medical								1/25	res 2□No	10	í⊻es 2□ No		
ding Phys h. Atterthis funeral d	TOB	examiner? \$\infty \text{Yes} 2 \text{No} 27. Manner of Deeth 1\$\infty \text{Natural} 5 \text{Pending} \text{investigation} \text{investigation} \text{3} \text{Suicide} 6 \text{Could not b} \text{6}		jury Jay Year)	A					me 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred					
		4 Homicide detarmined	building, e	etc. (Speci	(by)	m, street, factor		me, date end i		City or Tov	vn, Stete)		i Routa Number,		
2525	Medical	(Check only one) 29b. Signeture end title of certifier	Clure	of examine stated.	etion and	or Investigation	o, In my o				date end placa 29d. Date sign				
State	e	30. Name and address of person for Dennis J. (A) 31. Date tiled (100 Day Year)	ute no	111	l Per	n Stree	et, I	Baltimo	ore,	Maryla	and 212	01			
Registra	r	1444 66 69	O A	an well	1001/-	Mandelle.									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #7 Per FH Film g758 4-22-98RC 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month 18, 1998 VELVA MAE GRIFFIE 7:28 am April /Medical 4a. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Boltimore N/A Months Deys Hours Min. 8. Data of Birth (Month, Dey, Year) 5. Sociel Security Number 9. Birthplaca (Stata or Foraign Country)
MISSOURI 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 10 M 20 F 488-40-5655 62 Yrs. Director Usual Rasidence of Decadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director BALTIMORE MD 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 0 DRIVE ASHBRIDGE items 23a 2/22/ USA Funeral Was Dacedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after on ant of Health and Mental Hygiena. Int: If Item 27 Is marked other than "natural", or item 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No by Specify: 3 Widowad 4 Divorced BLACK Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-Aor 5+) WORKER 10 TH GRADE LOTHING 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) KEUBEN GRIFFIE MARY UNKNOWN 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Department of Health ar Important: If Item 27 is any injury or other trau BALTIMORE, ASHBRIDGE HRISTOPHER GRIFFIE SON 20b. Placa of Disposition (Nama of cametery, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Steta 4-23 98 4 ☐ Donation 5 ☐ Othar (Specify) METRO CREMATORY BALTO. MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Fecility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE BALTO. 23a, Part I. Enter the disclass, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Physician /Medical Immediata Causa (Final disaesa or condition rasulting in deeth) a Septic Shock 1 week Examiner Due to (or as a consequence of): Examiner Spontaneous BacteriaL Peritonitis many months Sequantially list conditions, if eny, laading to Immadiata causa. Entar Underlying Causa (Diseasa or injury that initietad avants resulting In daath) Last Dua to (or as e consequança of): physician the burial P.O. Box 68760 clostindium DIFFICILE Colitis one month The law requires that the death certificate be Physician/Medical Due to (or as a consaquence of): 88 Acute Renal failure one HEEK Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis with Ascites Division of Vital Records. þ Completed 24b. Wara autopsy findings availabla prior to completion of cause of deeth? 24a. Was an autopsy page 2 : cartificate 2 No 1 X Yas 1 Yas 20 No Hospital or Attending Physician: funeral director, 25. Wes casa referred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: 1 D(Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Othar: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To this 28a. Dete of Injury (Month, Day Yaar) 27. Mannar of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 5 Panding Invastigation 1 Natural s after death. 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicida 24 hours a edical 29a. Certifian t⊠ Certifying Physicten: To the best of my knowledge, deeth occurred at tha time, dete end placa, and dua to the cause(s) end manner es statad. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29b. Signatura and titla of certifier, 29d. Data signed (Month, Day, Year) (91 b504 30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print) (CABSON JOHNS HOPEINS HOSP, TAL 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Ichia Davidson Registrar

DHMH 16 Rev 6/95



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Item#17,18 per Mother G761 7/6/98EwState of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Item: 1 per Physician G-759 5/12/98 reb 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** EDWARD HALEY III 1998 6:45 AM April 6 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner BALTIMORE HOPKINS HOSPITAL JOHNS 7. Age (In yrs. lest birthdey) 30 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

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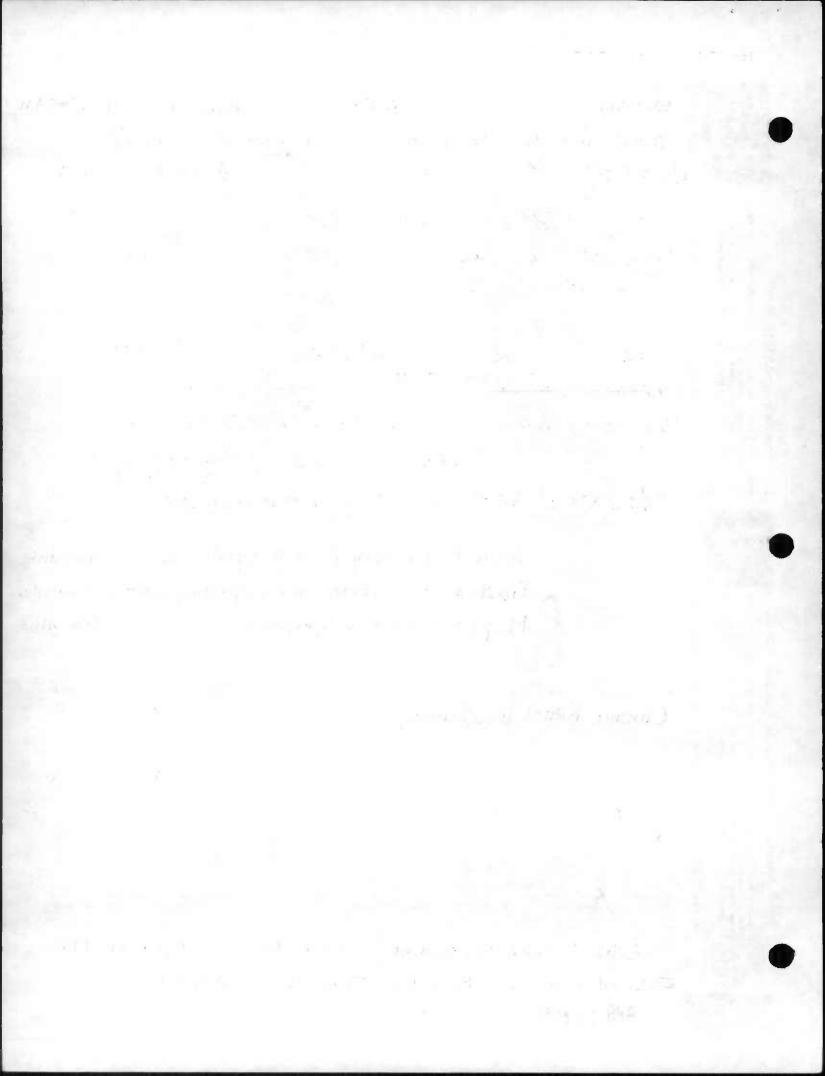
D 5. Social Security Number 6. Sex **Funeral** 100M 20 F Deys 216-82-9219 Usual Residence of Decedent **Director** the Merylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frame 23a or 28a-f show treumstic event, the Medical Examiner must be notified at BAHIMORE 1 TYes 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Numbe filed within 72 hours efter death with 4522 Funerai Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 Tho Specify: Specify: BIAC þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SALESMAN Hygiene. 10BACCO X 18. Mother's Name (First, Middle, Meiden Sumeme)
Brenda Rebecea Robinson 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be filt.
Department of Health end Mental Hy
Important: If Item 27 is marked otherly injury or other treumatic event Be Edward Carter Haley II BRENDA KEBINSON 19a Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) AVEBAITO, MD. 21214 HALE (WIFE) WE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Douriel 2 Cremation 3 Removal from State BUTUS MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility E. L. Ware the J Alector CFSP 1721-27 N. MONLOE ST.-Balto., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) e. Acute Respiratory Distress Syndrome Due to (or as a consequence of): 3 months **Examiner** Physician/Medical Examiner Bronchiolitis Obliterans with Organizing Proumonia 3 months Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physicien and 3 months . Idiopathic CD4 Lymphopenia Box 68760, Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. honic Kenal Insu 1 Yee 20 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed certificate hes 2 X No 2 X No or Attending Physicien: 25. Was cese referred to medical examiner? Certification: To Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 24 hours efter deeth.

Funeral Director: After this funeral 27. Manner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No thef 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner as stated.

| Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) RES OOO April 21, 1998 abelle Holatup, Kesident 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Tower 110 Johns Hopkins Hospital Elizabeth Holt, MD 32. Registre 's Signature Andall 31. Dete filed (Month, Day, Yeer) APR 22 Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Norman Hayes 15, 1998 April 4:20 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Villa St. Michaels Baltimore City Baltimore City If Under 1 Yaer | if Under 24 Hrs. | 8. Deta of Birth
Months | Days | Hours | Min. | (Month, Day, 7. Aga (In yrs. last birthdey) 76 Yrs. 5. Sociel Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1 № M 2 🗆 F 244-18-8838 July Director unknown Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or itsma 23a or 28a-f show traumetic event, the Medical Examiner must be notified at Maryland Baltimore City Baltimore 1√2 Yes 2 No Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 4800 Seton Drive 21215 U.S.A. "natural", or items 23s Funeral 12. Was Decedent Ever in U.S.
Armed Forcas? unknown
1 | Yes 2 | No
If Yes, Sive
Yaer or Dates: 11. Marital Status unknown 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, permit. Pages 1 and 2 should be fised within 72 hours after a Department of Health and Mental Hygiene. I important: It leem 27 is marked other than "natural", or there any injury or other traumetic event. Biack, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuai Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Melden Sumeme) Be unknown unknown 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Piece of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Other (Specify) in state Konald S. Wade, 22. Neme and Addrass of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or hear feilure. List only one cause on each line. Interval Between Onsat and Death Physician /Medical Immediete Ceuse (Finel metastatic Cancer disease or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner physician end s the burial-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): attending p sate has been signed by the page 2 should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ρ Completed 24b. Were autopsy tindings evelleble prior to 24e. Wes an autopsy performed? completion of cause of deeth? 1 Yas 25 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: director 25. Wes case reterred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3☐ DOA Other: 45 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2€No 2 this 27. Manner of Death 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury at Work? After 4 hours after deem. 5 Pending 1 Neturei 1 Yes 2 No invastigation 2 Accident 3 Suicide 6 Could not be determined 28a. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and menner stated. 29a. Certifier edicai 29b. Signature end titla of certifiar 29c. Licansa numbar 29d. Deta signed (Month, Dey, Year) who completed cause of deeth (Item 23e) (Type, Print) PARKHEIGHS AVE. BALTO. M.) Nodis MO 32. Registrer's Signeture 31. Date tiled (Month, Dey, Year) State APR 2 2 1998 Registrar

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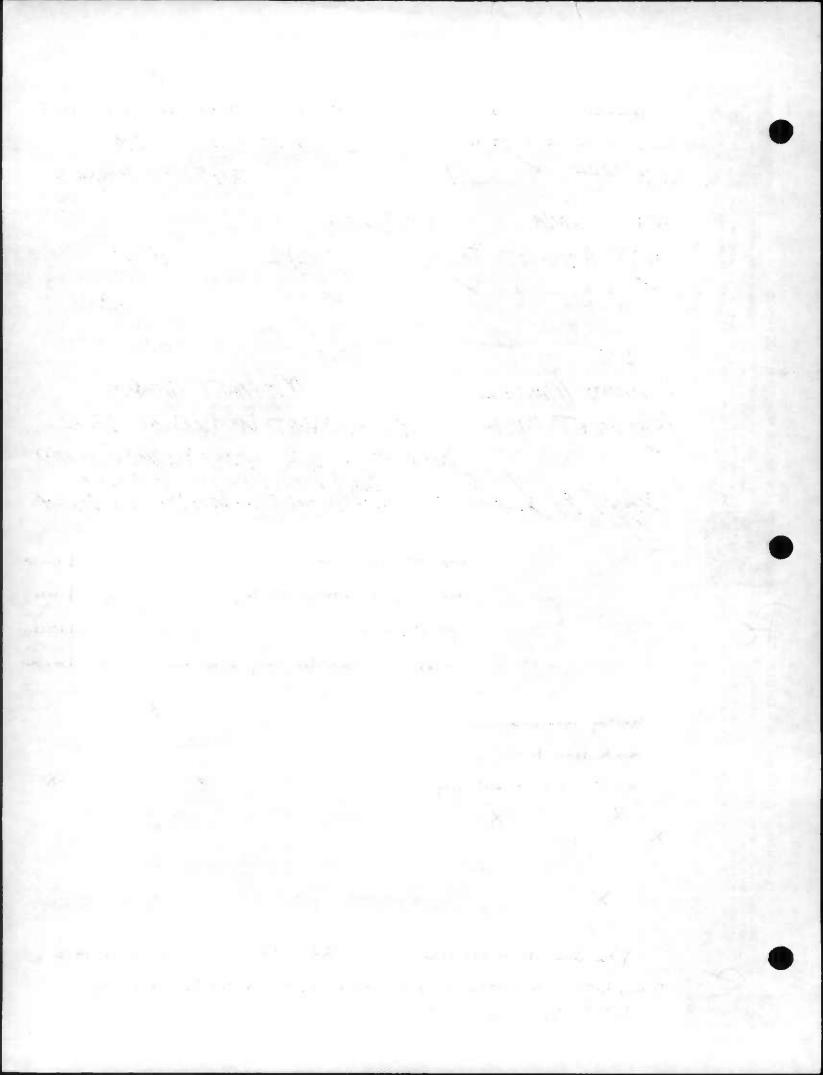
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State of Maryland / Department of Health and Mental Hygiene 8 2639

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ita al line al		28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural F									
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifiar Certifying Ph (Check only one) 2 Medical Exam	ystolan: To the best of my kno niner: On the basis of exemine and mannar stated.	owladga, daath occurred etion end/or Invastigation	d at tha tima, data and place n, in my opinion, daath occ	e, and dua to tha ca urred at tha tima, da	usa(s) and manns ita and placa, and	ar as stated. dua to tha causa(s)				
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State Registrar	31. Data filed (Month Day Year)	8 Julia Julia	alura Aandelle								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1:10 pm **GEORGE** 20 HALL APRIL 1998 Jr. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 1611 ELLIGSON ROAD ROSEDALE 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 14,1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Deys 1 M 2 □ F Months Hours 215169220 80 Yrs. MARYLAND Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Manyland Deperment of Health and Mental Hygiene. Deperments if from 27 la marked other than "naturel", or items 23s or 23s-f show any Injury or other traumatic event, the Medical Experiment and the notified at 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Directo MD BALTIMORE ROSEDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1611 21237 ELLIGSON ROAD USA Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 IXYes 2 □ No if Yes, Give Yeer or Dates: WW 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 Ves 2 XNo Specify: WHITE Specify: þ 3 Widowed 4 Divorced W II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) RAILROAD 0 FREIGHT BRAKEMAN 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) GEORGE R. HALL SR. BESSIE E. CHESTER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) DOLORES HALL/WIFE ELLIGSON ROAD 1611 ROSEDALE, MD. 21237 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete GARDENS OF FAITH 4/24/98 BALTIMORE, MD 4 Donetion 5 Other (Specifical 21. Signeture of Funerel Service Ligard 22. Name end Address of Fecility
CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of) or Attending Physician: The law requires that the death certificata signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been si 24a. Wes en eutopsy Completed certificata hes b 1 Yes 2 No 1 ☐ Yes 2 1 No director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 8 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? within 24 hours aftar death.

To the Funeral Director: Aftar completaly filled in by the funer 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office bullding, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certified

State Registrar

31. Dete filed (Month, Day, Year)

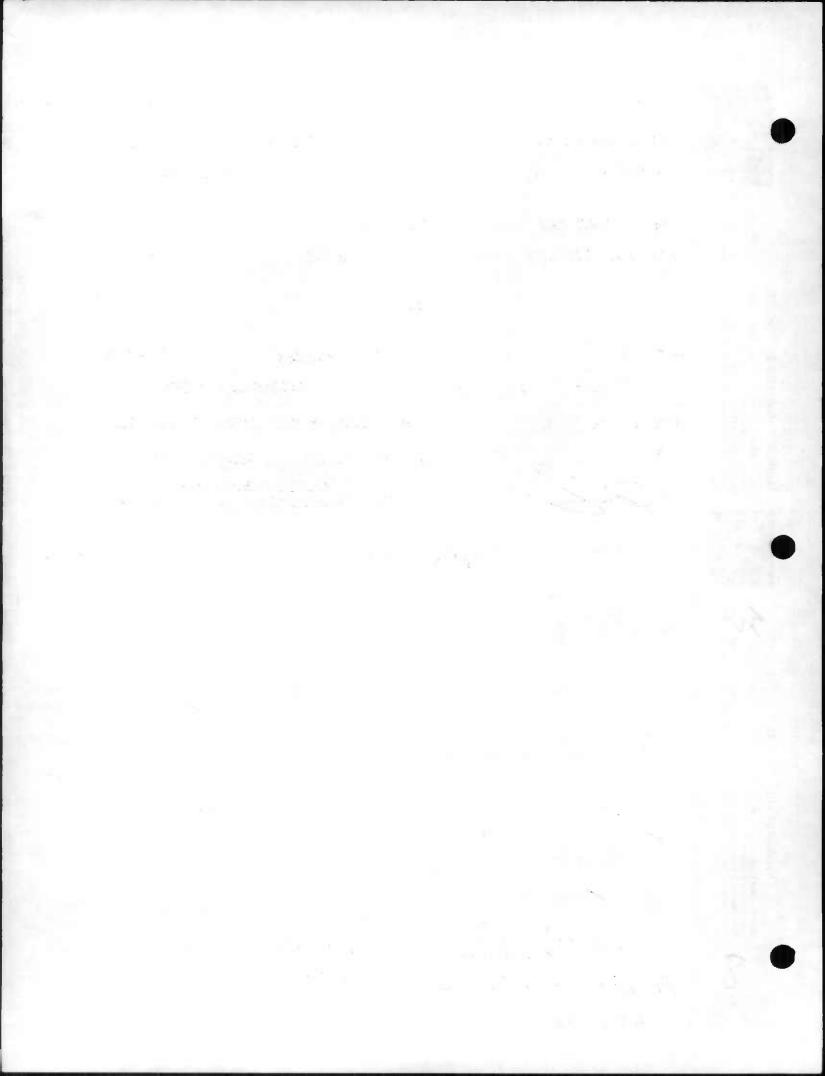
30. Name end eddress of person who completed cause, of deeth (item 23e) (Type, Print)

Registrer's Signeture Julia Davidson

hathan

1012 OND North Point Rd. Baltimore, md, 21224

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Item: 10b, c per F.H G-758 4/22/98 re Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Daath Month **Physician** GERALD HAWKES 45 PM 1998 20 /Medical 4a. Facility Neme (If not institution, giva street and number 4b. City, Town, or Location of Daath 4c. County of Death Examiner Baltimore
H Undar 1 Yaer H Undar 24 Hrs. 8 5. Social Sacurity Number yrs last birthday) 55 Yrs. Birthplaca (Stata or Foreign Country) **Funeral** 12 M 2□ F 219-40-5722 Days Director Usual Rasidance of Dacedant the Maryland 10b. County BAL MORE 10a State 10c. City, Town or Location 10d. Insida City Limits 28a-1 show pernit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show eny Injury or other traumatic event, the Madical Examiner must be notified at 1 Yas 2 No WOODLAWN Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6802 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 Xyas 2 □ No If Yas, Giva Yaar or Datas: Wes Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Black, Whita, atc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Malden Surnema) HAWKES SR. uvenia 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typa, Print) DR. Hngela 6802 BACTO. MO 21207 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crametory or other place) Data 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funeral Service License 22. Nama and Addrass of Facility P. WY/LE FUNERAL HM PA 25a. Part 1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiec or respiretory arrest,

Approximate **Physician** a END STAGE /Medical Immediate Ceuse (Finel diseasa or condition resulting in death) Examiner Examiner NEUMONIA -transit nding Physician: The law requires that the deeth certificate be executed Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) and physician ar s the buriel-t P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the ceuse of deeth? 3 Probably 4 Unknown 1 Yes 2 No RENAL FAILURE sion of Vital Records, 2 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was cesa referred to medical 26. Placa of Daath (Check only ona) Hospital: 1 Yes 21 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Impatiant 3□ DOA 2 ER/Outpatient this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 113 Certifying Phyeicfan: To the best of my knowledga, death occurred at the time, date end piece, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and piece, and due to the causa(s) and mannar stated. Medical 29e. Certifiar (Check only one) 29b. Signetura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) 30. Nama and address of person who complated ceusa of death (Item 23a) (Type, Print) Mubarak, M.D. Abdullah

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Dey, Yaar)

32. Registrar's Signetura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth Month APRIL 09:20 Jafri Binte 17 1998 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUFEL 7. Aga (In yrs. lest birthday) If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 24, 19 Birthplace (State or Foreign Country) Sociel Security Number Months Deys Hours Min 10 M XX F UNKNOWN 73 Yrs. 1924 India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2/7 No Prince George's Maryland Laure1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8248 Northview Court 20707 Pakistan 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 X X o If Yes, Give Yeer or Detes: 1 Never Marriad 2 Married 1 ☐ Yes 2 X X o Specify: Asian 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker own home none 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fethar's Name (First, Middle, Last) Ahmed Syeda Khatoon 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Syed Qamar Abbas Jafri (son) same as #10 20b. Placa of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition Date Buriel 2 Cremetion 3 Removel from State Maryland National Memorial Park 4/18/1998 Laurel, Maryland a of Funeral Service Lice 22. Nama and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or confplications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one ceusis is each line. Approximate intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) · ARTELIOSCUERETIC CARDIOVASCULAR DISEASE Due to (or es e consequence of) Due to (or es e consequence of) Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yas 2 No 3 Probably DEPRESSION 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 2 No 26. Piece of Death (Check only one)

Physician /Medical **Examiner**

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After this funeral

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The law requires that the death certificate be executed

Box 68760,

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Division of Vital or Attending Physician: Physician/Medical Examiner

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Physician

/Medical

Examiner

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Funeral

Director

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Completed

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the Manyland

72 hours after

permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygione. Important: If then 27 is marked other than "I

Baltimore,

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in deeth) Last

25. Was case referred to medicat exeminer?

1 Yes 2 □ No Hospitel: 1 Inpatient 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 1 Neturel

5 Pending invastigation 2 Accident 6 Could not ba 3 Suicide 4 ☐ Homicide

2 ER/Outpatient 3□ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work?

1 ☐ Yes* 2 ☐ No 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

29a. Certifier (Check only one)

R 22 199

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier

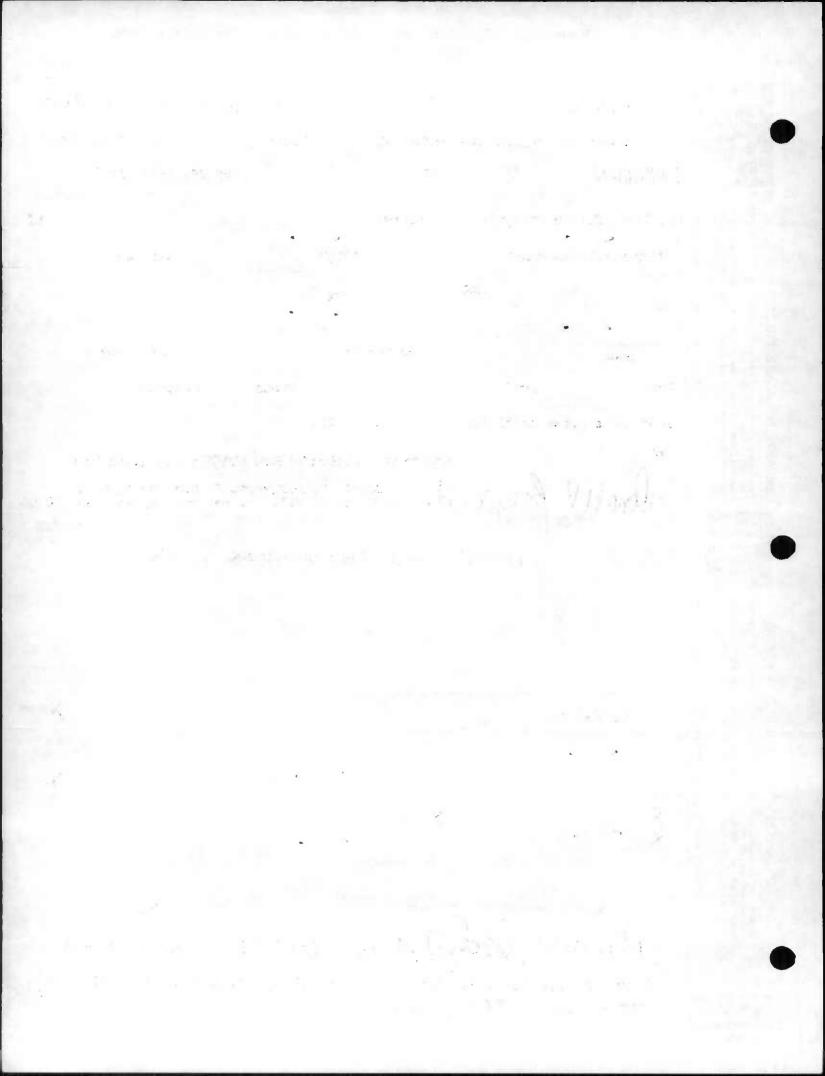
29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death/(Item 23a) (Type, Print)

MARIO GOW 3001 31. Dete filed

HOSPITAL DRIVE CHEVERLY, MARYLAND.

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ohnson **Physician** 17:52 1998 ames April 1 4c. County of Death /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner Baltimere

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Bultimore Johns Hop Kins Hospi tal Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** Months 1∏M 2□F 219-88-0843 Yrs. 33 Director Md Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Examiner must be notified at Md NA YYes 2□ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after deeth w Department of Health and Mental Hygiene. If Item 27 is merked other than "natural", or items 23a any injury or other traumatic event, the Medical Expense 21218 2501 Barclay St. USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ⁵ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ★Never Married 2 Married 1 Yes 2√ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Handyman 12th Grade various trades NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Arthur Boatwright Mildred Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 19a. Informant's Name/Relationship (Type, Print) Jackie Johnson 730 New Pittsburg Avenue Baltimore, Md. 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Suriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 04-18-98 Dundalk, Md. Sign filtre of Funeral Service Licen 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. **Physician** 30 min /Medicai Immediate Cause (Finel disease or condition resulting in death) **Examiner** Physician/Medical Examine Tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, The law requires that the deeth certificate be Due to (or as e consequenca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detecha 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Hypothelamic Tumor Chronic p 24b. Were autopay findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy Insufficiency No No 1 Yes this certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Director: After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 1 Naturel 5 Pending 1 Yes 2 No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as atlated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier Neurosurgery

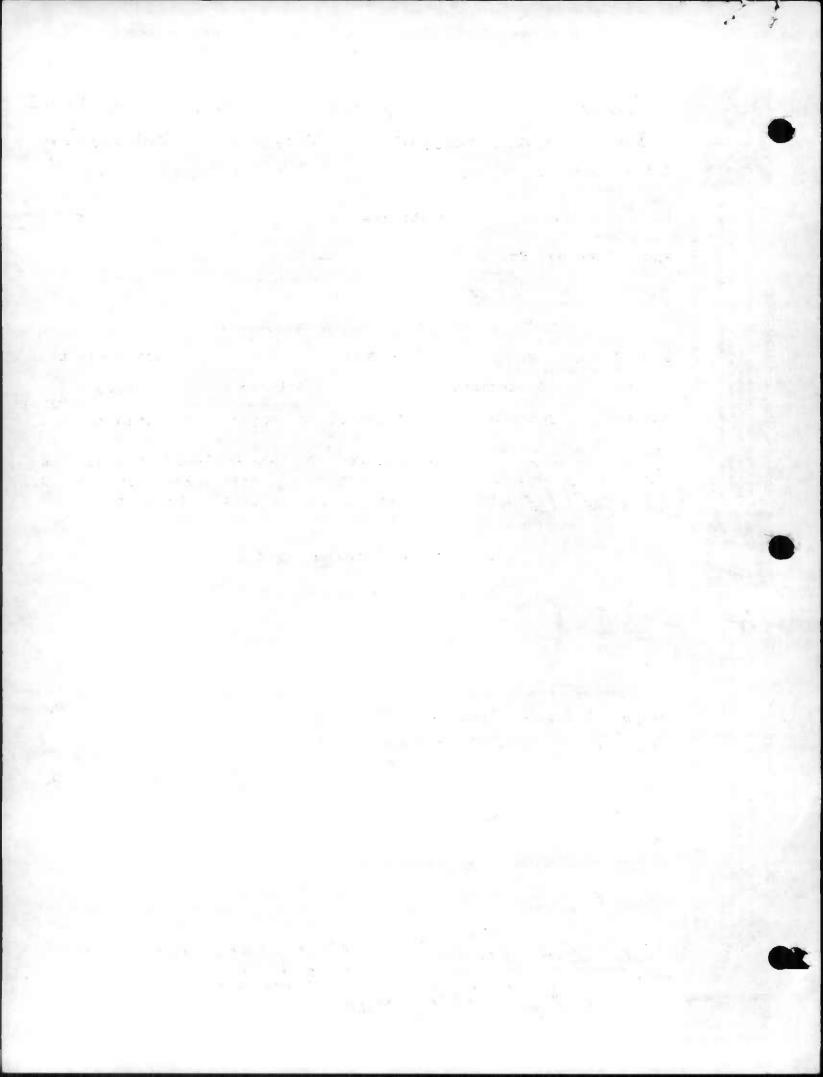
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Or Dean Choufe Street, Bultimore, Maryland

State Registrar CHOU

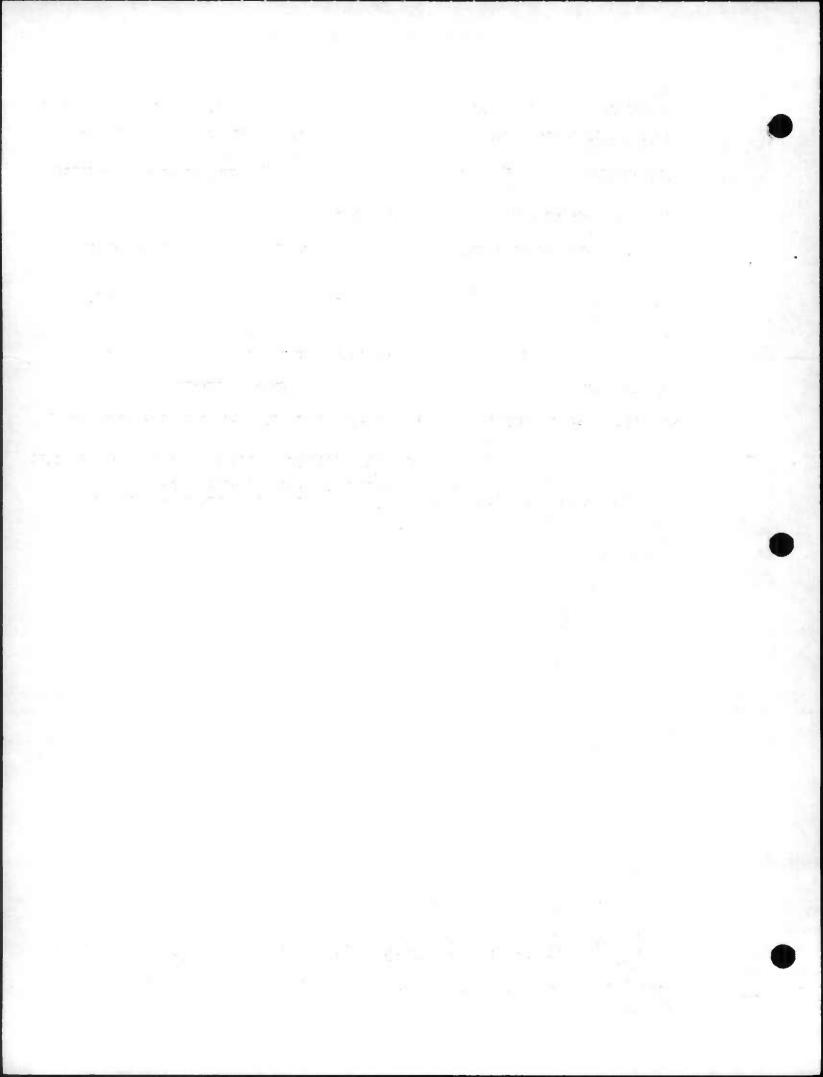
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

tospital

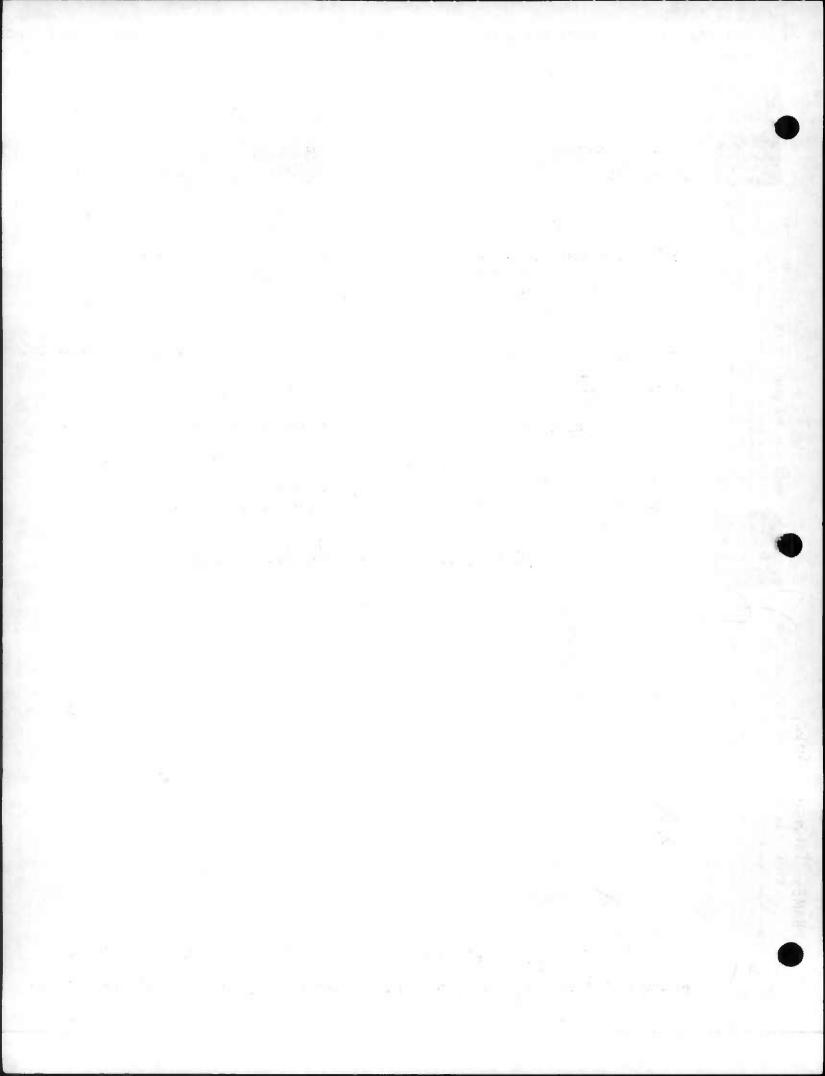


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 | 2644

					,	Certificate of	Death		Reg. No.	1 6.	.044					
	Physici	an.	1. Decedant's Nama (First, Middla, Li					2. Data of De	ath	Yaar	3. Tima of Death					
	/Medi		DOROTHY	W. JUD	Υ	1	th City Town or		18, 199		7:15 AM					
	Examir	er	4a. Facility Nama (If not institution, gi WILSON HEALTH CA	RE CENTER			SAITHER			TGOME!	RY					
	Funeral Director			THE OFF	(In yrs. last bir 97	thday) If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da AUG. 2	12,1900	9. Birthpl Count NEW	ace (Stata or Foreign JERSEY					
	Maryland a-f show Uffed at	ctor	10a. Stata 10b. County MD. MONTGO	MERY	10c. City, Tow GA	or Location ITHERSBURG				10	od. Insida City Limits 1 MYas 2 □ No					
	ifs with the 23s or 28 ust be no	Funeral Director	10e. Street and Number 107 B. NORTH SU	MMIT AVENU	E	10f. Zip Coda	20877		10g. Citizen of UNITED	What Count STAT	ES					
21215-0020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heelith and Mental Hygiene. Important: if item 27 is merked other tran "natural", or items 23a or 28a-f show any injury or other traumetic event, the Hadical Examiner must be notified at once.	by	11. Maritai Status 1 Nevar Married 2 Married 3 SWidowed 4 Divorced	12. Was Decedant E Armad Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:		13. Was Decedant of H If Yas, specify Cuba 1 ☐ Yas 2 ☑ No		pecify Yas or No o Rican, atc.)		ce - Amarica ck, Whita, a y: WHI	itc.					
5-0	netu notcel	etec	15. Dacedant's E (Specify only highast gr	ducation ada complated)	16a.	Decedant's Usual Occup (Giva kind of work dona	during most of war	king	16b. Kind of B	usinass/Ind	ustry					
212	withir ene. then	Be Completed	Elemantary/Secondary (0-12)	Coilega (1-4or 5-	-)	EXECUTIVE		2.4	LAW	FIRM						
bu	other officer	e C	17. Fathar's Nama (First, Middla, Las			ENLOGITYE	18. Mothar's Nar									
Val	Menta Menta arked etic	To	ALBERT WAYNE				EMMA	GRIFFI	TH							
. Maryland	end 2 sho eelth end n 27 is m		PATRICIA W. ADAM,		10	Malling Addrass (Street ANORTH SUI										
Baltimore.	Pages 1 Iment of H lant: If iten jury or oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cematai	Disposition (Nama of y, cramatory or other place OLITAN CREM		Data 4/19/98	ALEXAN		wn, Stata VIRGINIA					
Bal	permit Depart Import any in		21. Signature of Funarai Sarvica Licansaa MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 2088													
			23a. Part1. Entar tha disaase, of con shock, or haart failura. List only	plications that causad to ona causa on aach line	tha daath. Do r a.	not antar tha moda of dyin	g, such as cardiac	or raspiratory a	rrest,		Approximata Intarval Between Onsat and Death					
	Physician /Medical		Immediata Causa (Final diseasa or confident as Concustive heart for him													
	Examiner		diseasa or condition rasulting in daath)	a	OV SC	consequance of):	east to	ailmi		i	1 day					
	P #	Iner		h	(0, 11)					1	•					
Ö.	rificata be executed ng physicien and es the bunel-transit	Ped	Sequentially list conditions, if any, leading to Immadiata cause. Entar Underlying Causa (Disaasa or Injury that initiated events	D	ua to (or as a	consequance of):										
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	ne deeth cer the ettendir thed for use	Physician/	Part II. Other significant conditions	contributing to death but	not resulting Ir	tha undarlying causa give	an in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?					
P.O	as that the de igned by the be detached	by Phy	cerebrovo	rcular	dire	aul		10	Yes 24 No	3 Prob	ably 4 Unknown					
Records,	requir been s should	Completed t						24a. Was	an autopsy prmed?	ava	ra autopsy findings ilable prior to apletion of cause aath?					
R		Con						10	Yas 2000	1□	lYas 2□ No					
of Vital	Physician: The this certificate ral director, pag	Be	25. Was casa rafarred to madical axaminar?	Hospitai:		Oth.	26. Placa of Dea									
	Phys this	7: To	1 Yas 2010 27. Mannar of Death	1 ☐ Inpatian 28a. Data of Injury (Month, Day		tpatient 3 DOA Out	4) Nursing H		danca 6 Oth)					
) o	Attending Fir death. Sctor: After by the funer	atlor	1. Natural 5 Panding 2 Accidant invastigatio		Year) li		k? Yas 2□No									
Division	248	Certification:	3 Sulcida 6 Could not be datarmined	28a. Piace of Injurbuilding, atc.	y - At homa, fa (Specify)	rm, street, factory, office		28f. Location (City or To	Street and Numb wn, Stata)	ber or Rural	Routa Number,					
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Pr	nysician: To the best of niner: On the basis of a and manner state	examination and	, daath occurred at tha tin d/or invastigation, In my o	na, data and piace pinion, daath occu	, and dua to tha rred at tha tima,	causa(s) and madata and piaca,	annar as ste and dua to	ated. tha cause(s)					
	To the Comp	ž	29b. Signature and titia of certifier	10 0	Λ	29c. Licansi	a number		29d. Data signe	d (Month, L	Day, Year)					
			John 12	. Melw	el n	D19	1294		April	18,	1998					
			30. Name and addrass of person who	complated causa of dec	ath (Itam 23a) (Type, Print)	Harla.	11.0	20179							
	Sta	te	31. Data Hill Month, Day, Year)	320 Redistrac	's Signature	The Cod	· I vacing	, moe	201/							
	Registr	ar	APR 2 2 1998	Julia Da	Mason-R	ndell.										



		Decedent's Neme (First, Middle, Las.)			71 (1110)	110 0	f Death	2. Dete of De	Reg. No.		3. Tima of Death		
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/Medic Examin		4e. Fecility Name (If not institution, give		JUII	nson,	31		4b. City, Town, or I	April Location of Deet		1998 ty of Death	0743		
uneral rector	er	St. Agnes Hospital 5. Social Security Number 6. Se 213-16-3354	y) If Und Month	der 1 Yee s Day	Baltimore or If Under 24 Hrs.	e MD			lece (State or Foreig try) Md					
4		10a. State 10b. County		10c. C	ity, Town or I	Location			10d. Inside City Lim					
	ctor	Md N/	P	В	altimo	re					XXYes 2□			
	Director	10e. Street end Number					Zip Code			-	of What Country?			
	ral	3217 Massachuset					2122			US				
	by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? XXYes 2 If Yas, Give Yaar or Datas:		J,S. 13	. Was Dec If Yas, sp 1 ☐ Yas		Hispanlc Origin? (Suben, Mexican, Puart o Specify:	pecify Yas or No o Rican, etc.)	Yas or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black				
1	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dec	edent's Us	suel Occ	upation	kina	16b. Kind of	Business/Ind	lustry		
	Jd L	Elementary/Secondery (0-12)	College (1-4or	5+)			use reti	na during most of wor red)	ning.	Conn	or s 1	Brace Co		
	ပ္ပ	7th grade 17. Fether's Neme (First, Middle, Last)	N/A		Lat	orer		18 Mother's Nan	Copper & Brass C					
	To Be	Charles Johnson				18. Mother's Name (First, Middle, Meiden Surneme) Marie Burgess								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Timportant: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		19e. Informant's Name/Reletionship (7)	rpe, Print)		19b. Mei	iling Addre	ss (Stre	et end Number or Ru		er, City or Tow	n, Stete, Zip	Code)		
		Virginia Johnson	- Wife		32	217	Mass	achusetts	Avenue	Baltim	ore. M	ld 21229		
		20e. Method of Disposition	lomovol from State		Place of Disp cemetery, cr	position (N	leme of		Dete		20c. Location - City or Town,			
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		21. Signature of Funerel Service Licensea 22. Neme end Addrass of Fecility March F/H West												
l		Dunie	5- A0	2	(Qu	430		/H West abash Ave	nue B	altimor	e. Md	21215		
Physician /Medical Examiner		23a. Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Intervel Betwoen the disease or condition resulting in deeth) Due to (or es e consequence of):												
	n/Medical Examine	if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events caushing in deeth) Lest Due to (or es e consequence of):												
	sicia	Pert II. Other eignificant conditions cor	23b. Did tobacco use contributa to the cause of death											
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	Certification:	3 Suicide 6 Could not be determined	е	28f. Location (City or To		nber or Rurel	Route Number,							
	edical	29a. Certifier (Check only one) Certifying Physical Exami	nician: To the best of ner: On the basis of and mannar sta	examine	owledge, dee etion end/or l	th occurre	d et the	time, dete end pleca opinion, deeth occur	, end due to the rred et the time,	ceuse(s) and r dete end piece	nenner es ste o, and due to	eted. the cause(s)		
	ž	29b. Signatura and title of certifier				2	9c. Licar	nsa number		29d. Dete sign	ed (Month, L	Dey, Year)		
		30. Neme end eddress of person who co	mpleted cause of d	hys	1 C1 NO (Type	, Print)	D	51853		April	20, 1	998 nd 21220		
1		Michael Silverm			aint A		Ho	ospita)	Boltin	10/e /	Nacula	nd 21220		



State of Maryland / Department of Health and Mental Hygiene Q 2 1 2 6 1.

			A STORCH	EN					2. Dete of Dec MAR th 3(Year	3. Time of Death 9:34PM			
/Medical	do Coellina blome							4b City Toy	am or Loc	ation of Death		y of Death	9;34PM		
Examiner			AVAL MEDI	CAL CEI	NTER			BETHE	SDA	ation of boats		NTGOM			
uneral rector	Second Security Number 10	Number -2189	6. Sex 1 ☐ M 2 ☐ XF	7. Age (in yr	rs. lest birthday 89 Yrs.	/) If Und Month	der 1 Year s Days	If Under 2 Hours	Min.	8. Date of Birl (Month, De June		place (Stete or Forei ntry) w York			
ž=		of Decedent 10b. County		10c. (City, Town or L	ocation					10d. Inside City Limits				
tor	VA	Fair	fax		Falls	Chu	rch						1 ☐ Yes 2 📉 N		
or 28		lumber					Zip Code				10g. Citizen of What Country?				
23a	3440 S	Jeffers									USA or No- 14. Race - American Indian,				
by E	1 Never Ma	arried 2 Marr	Armed F ried 1 Ves If Yes, G	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		13. Was Decement of Hill If Yes, specify Cubar		Hispanic Origin? (Specify Yes or Niban, Mexican, Puerto Rican, etc.) Specify:			- 14. Ra Ble Speci	cen Indian, etc. WHITE			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month 17 - 1998 4:55 PM SALLIE M. JOHNSON 4 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Nama (If not institution, give street and number) (HOME) 2508 ELSINORE AVE. BALTIMORE 7. Aga (In yrs. last birthday) 78 Yrs. If Undar 1 Yeer if Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foraign 1 M 201 F Months Days Hours Min 217-24-9003 8-28-1919 VIRGÍNIA Usuel Residence of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No BALTIMORE N/A 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 2508 ELSINORE AVE. 21216 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, Whita, atc. 11. Merital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify AFR. AMERICAN 3 ☐ Widowad 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elemantery/Secondery (0-12) Collage (1-4or 5+) DOMESTIC WORKER 0 DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumeme) WILLIE TISDALE SYLVIA LEE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) FRANK JOHNSON (SPOUSE) 2508 ELSINORE AVE. BALTIMORE MD 21216 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State GARRISON FOREST V.A.CEM.4/22/98 4 ☐ Donation 5 ☐ Othar (Specify) OWINGS MILL MD 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signatura of Funaral Sarvica Licansee EUGENT WALKER 1300 EUTAW PLACE BALTO. MD 21217 23a. Part1. Entar tha disaase, or complications that shock or heart feilure. List only one cause of ed tha death. Do not antar tha moda of dying, such as cardiac or respiretory arrast, Approximata Interval Batwaan Onsat and Death Immediata Causa (Final diseasa or condition resulting in deeth) Due to/for es a consequence of): Dua to (or as a consaquance of) Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Chack only one)

Physician /Medical Examiner

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Vital Records,

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Physician

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Examiner

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with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiena.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic avent, the Medical Examiner must be notified at once.

altimore, Maryland 21215-0020

Examiner Saquantially list conditions, if any, laading to Immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Lest Physician/Medicai g Completed

1 Yas 2 No

27. Menner of Deeth

1 Natural

3 ☐ Suicida

29a. Cartifian

2 Accidant

4 Homicide

(Check only one)

31. Date filed (Month, Day, Yaer) APR 2 2 1998

6 Other (Specify)

Other: 4 Nursing Homa 5 Aasidanca 28d. Describe how Injury occurred 28c. Injury at Work? 2 No 1 TYas

Location (Straet end Number or Rural Routa Number, City or Town, Stata)

1 🔁 Cartifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and placa, end dua to tha cause(s) and mannar as statad. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mennar steted.

29b. Signature and rigin of certifies

5 Panding invastigation

6 Could not be determined

29c. Licensa number D 3568 S

3□ DOA

addrass of person who completed cause of death (Itam 83a) (Type, Print)

A Carry Completed Cause of death (Itam 83a) (Type, Print)

A Carry Completed Cause of death (Itam 83a) (Type, Print)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient

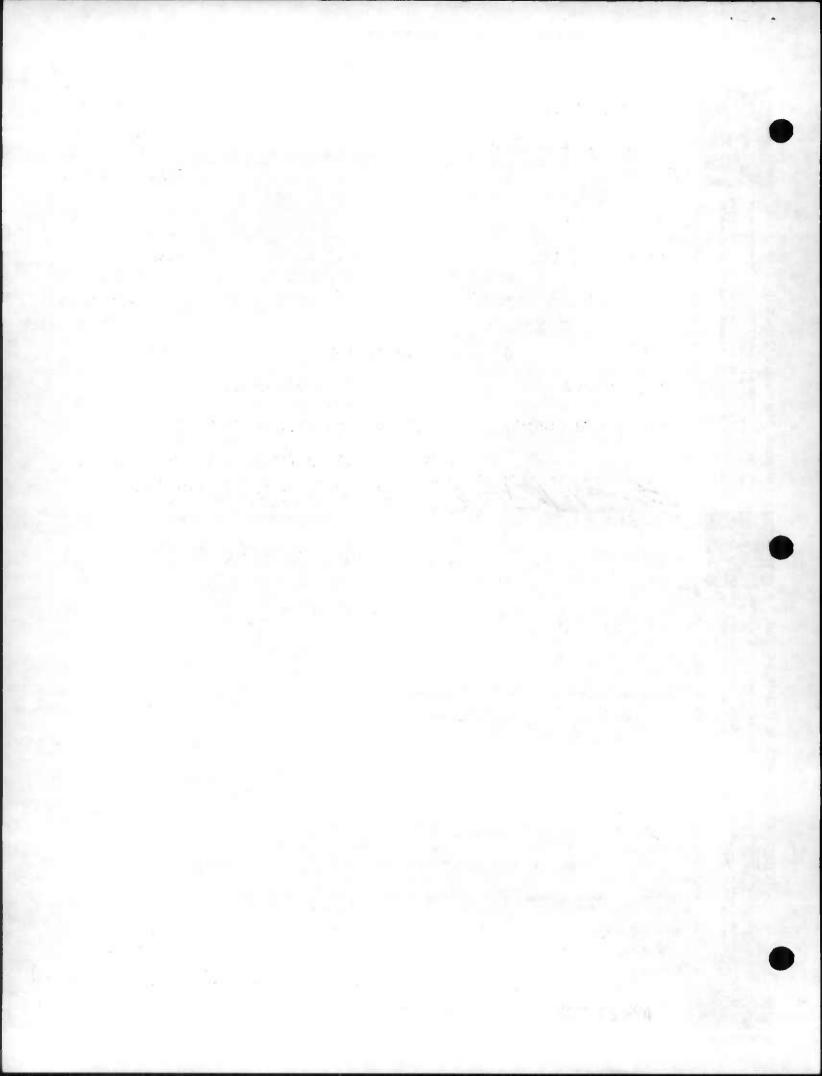
28b. Time of

28e. Place of Injury - At home, farm, straet, fectory, office building, etc. (Specify)

28a. Data of Injury (Month, Day Year)

State Registrar

within 2



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month April 08, 1998 **Physician** Rosemary Jones 2104 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hockins Hospital **Baltimore** N/A If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth
(Month, Day, Year)
June 12, 1910 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** Hours 1 □ M 2 ₽ F West Virginia 309-09-0058 Vrs 87 Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits Mode item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 22 Leeway 21222 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter death. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or Items 23, any injury or other traumatic event. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 □ Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker County Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be 2 Thomas Albright Frances Meredith 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8715 Greens' ane, Randallstown, Md. 21133 Richard Jones/Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 4-14-98 Elkridge, Md. 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory erre shock, or heert feilure. List only one cause on each line. 2134 Willow Spring Rd., Baltimore, Md. 21222 Intervel Between Onset end Deeth **Physician** /Medical immediete Ceuse (Final disease or condition resulting in deeth) e. Fungal Sepsil
Due to (or as e consequence of): Examiner Fundle plication Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In death) Lest physicianal s the bural P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No funeral director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA To the Hospital or Attending Phys within 24 hours effer death.

To the Funeral Director: After this 27. Menner of Deeth 28h Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 5 Pending investigation Naturei Accident 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Res 000 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 0 600 North Wolfe Street Balt, more MD 21287 Stephen Aufdenharde 31. Dete filed (Month, Day, Year) 32. Registrar 32. Registrar's Signeture State APR 2 2 Registrar

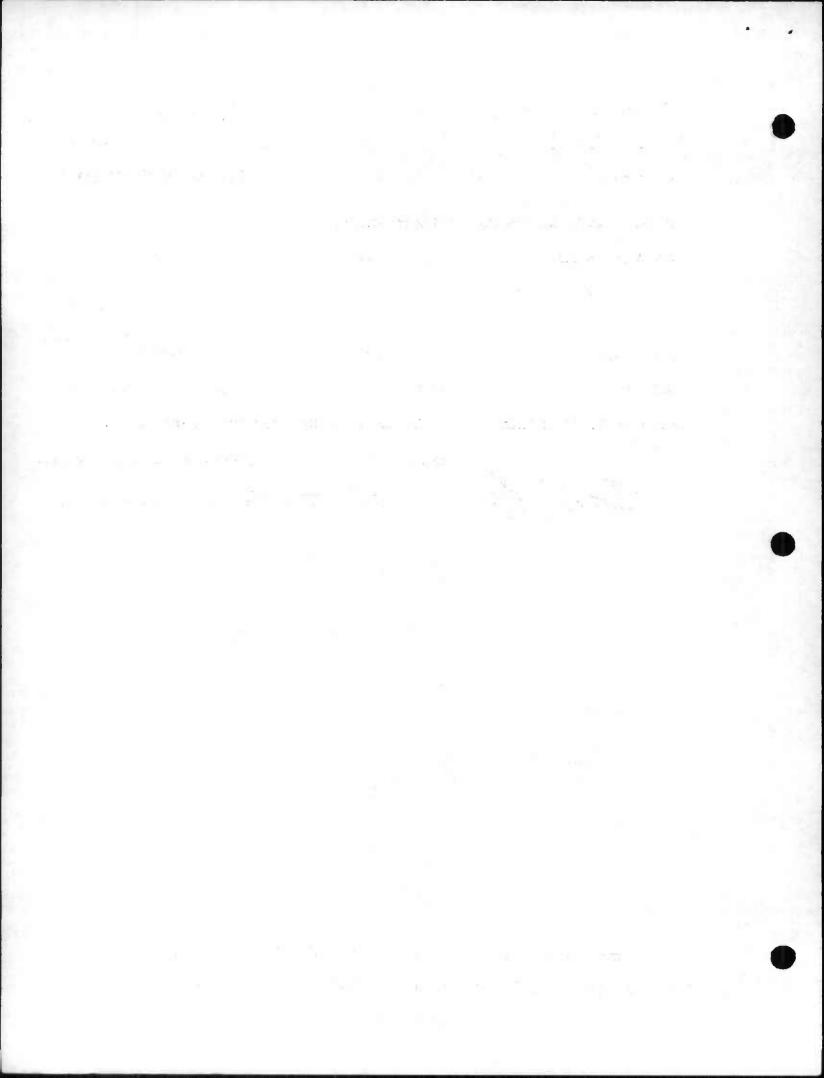


State of Maryland / Department of Health and Mental Hygiene

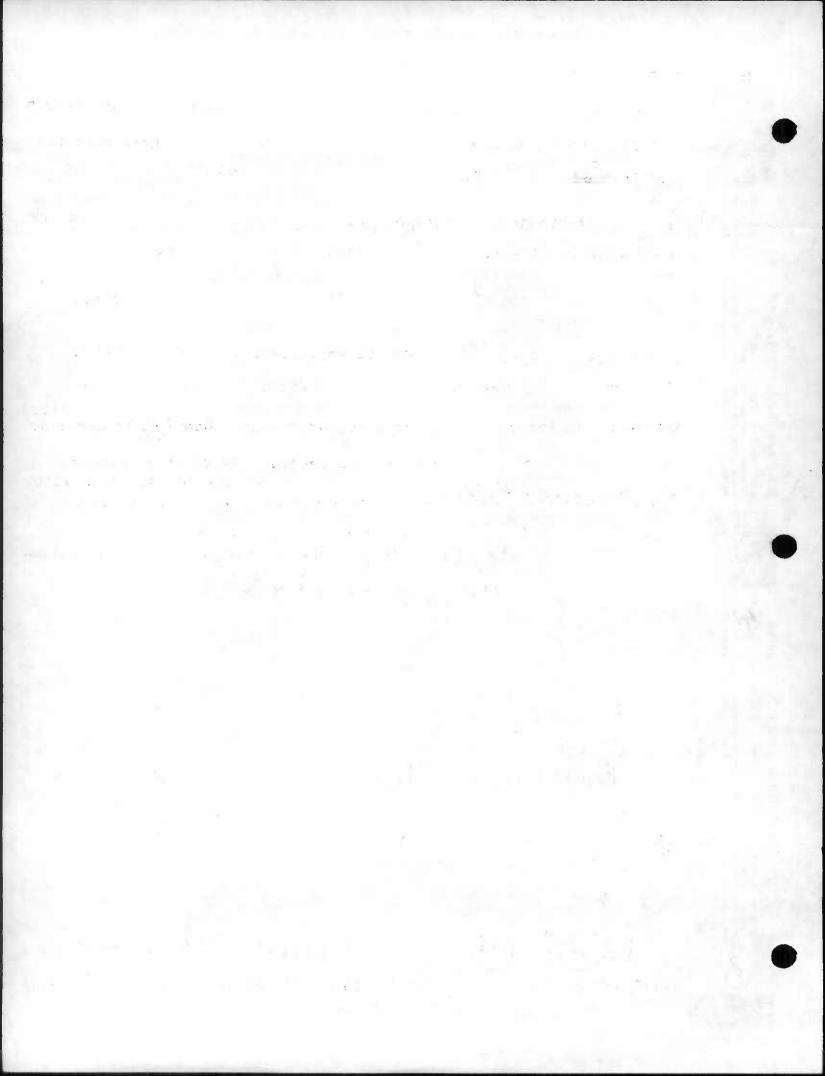
						Cen	tificate of	Death	,	Reg. No.	12649				
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	Funeral Director	ier	Franklen wood: 5. Sociel Security Number 6. S	s Center	e (In yrs. ia	st birthday) Yrs.	If Under 1 Year Months Deys	Balte If Under 24 Hrs.	8. Dete of Bi (Month, Di Jan. 1	rth ay, Year)	9. Birthplece (State or Foreign Country) Maryland				
	Aarylend show	٥٠	10a. State 10b. County	Combo	,	Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 🖾 No				
	h with the N 13a or 28a-f	al Director	Maryland Baltimon 10e. Street and Number 1216 Berk Avenue	ce County	Rose	аате	10f. Zip Code 21237			10g. Citizen of V					
21215-0020 1 within 72 hours 8 liane. r than "neturel", o	by Funeral	11. Merital Stetus 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 2 Yes 2 1 1 If Yes, Give	1 XYes 2 No If Yes, Give Unknown 1 Yes 2 X Yeer or Dates Unknown			Hispenic Origin? (Si pan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	5 Specify	e - American Indian, ck, White, etc.					
	Completed	15. Decedent's Ec (Specify only highest gre Elementary/Secondery (0-12) 12th Grade	lucation	i+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use ratired) Steel Worker		petion during most of word ad)	king	Steel N	usiness/Industry Manufacturing					
Maryland	aryland 2 should be filed of marked other urnatic event, to	To Be C	17. Fether's Neme (First, Middle, Last) Bernard		Kropp Anna						Dobropdski				
			imore,												
Baltimore,	permit. Pege Department of Important: If any Injary or price.		21. Signature of Fureral Service Licensee 22. Name end Address of Fecility John C. Miller, Inc. 6415 Polair Pond Paltimore Margaland 212												
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cornected, or heart failure. List only immediate Ceuse (Finel disease or condition resulting in death)	0	Inc.		ic G	ing, such as cardiac	or respiratory e	errest,	Approximate Interval Between Onset and Deeth				
x 68760,	oxecuted by and riekrapsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	C	Due to (or e	es e consequ	ence of):								
P.O. Box	that the death car ned by the ettendin a detached for use	/ Physician/Medical	Part It. Other significant conditions or	ontributing to death be	ut not result	ing in the un	derlying cause g	iven in Part I.		tobacco uee co	Company den Sumame) Dobropdski. dity or Town, State, Zip Code) ryland 21237 c. Location - City or Town, State altimore, Maryland , Maryland 21206 Approximate Interval Between Onset and Deeth Coco use contribute to the cause of death' 2 No 3 Probably 4 Unknown utopsy diff completion of ceuse of death?				
Records,	ew requira: 1s been sig 2 should b	Completed by													
VItal F	Physician: The Introduction of the Introductio	Be	25. Wes case referred to medical exeminer?	Hospitel:			0	28. Piece of Dee	th (Check only						
of	ing Phys L. After this uneral di	ation: To	1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injui (Month, Day		R/Outpatient 28b. Time of Injury	28c. Inju	4LE Nursing H	ome 5 ☐ Res 28d. Describe						
Division	r At Irecl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc			(Street and Numb wn, Stete)	per or Rural Route Number,							
	To the Hospital or within 24 hours effer To the Funeral Dir completely filled in	Medical													
	To with	~	29b. Signeture end title of certifier	apate	M	Œ.	D 5	se number		4.17					
	1021		30. Neme end eddress of person who are Ralapate.	2005 Fr	eeth (Item 2	23e) (Type, P	rint) B Dvc	ce. Ba	alter	icse.	21237				

Registrar

Dete filed (Month, Day, Year) APR 2 2 1998



	Item#5 p	er	FH G758 4/29/98 EW	State of M	Marylan		artment of		d Mental	Hygiene Reg. No.	8	2650		
			1. Decedent's Neme (First, Middle	e, Last)			A		2. Dete d			3. Time of Death		
	Physicia	_	Cuanio	Lee	Larre	700			Month		1, Yeer	8:00am		
	/Medica	_	Gussie 4e Facility Neme (If not institution)		Laws	5011		4b. City, Town	or Location of 0					
	Examine	r			ille	lle Baltimore								
-	-		2506 Edgew			lest birthday)	If Under 1 Year			of Birth		thplece (State or Foreign		
и	Funeral Director		5. Sociel Security Number 85/0	1□M 21XF	81	Yrs.	Months Deys	Hours	Min. (Monti	8. Date of Birth (Month, Pay Year) 03-07-17 9. Birthplece (Sta				
Ц		1	280-18-7599 Usuel Residence of Decedent		31									
	yland		10e. Stete 10b. County		10c. City	y, Town or La	ocation					10d. Inside City Limits		
	Man Man	Ď	Md Park	kville	Bal	timor	e Co.					1 ☐ Yes 2√DXNo		
	288 1000	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of Whet Co	ountry?		
	ath with the Marylan 23a or 28a-f show	0	2506 Edgewood	od Avenue			21234	34 USA						
	72 hours effer death with the Maryland natural, or items 23e or 28e-1 show circal Examiner must be notified at	Funeral	11. Maritel Stelus	12. Wes Deceder	nt Ever in U,	S. 13.1	Wes Decedent of	Hispenic Origin	? (Specity Yes		14. Rece - Ame			
0	fter dea	בַּ	1 Never Married 2 Marri	Armed Force			If Yes, specify Cul		uerto Rican, etc	.)	Black, Whit	le, etc.		
020	or or	þ	3☐Widowed 4☐Divorced	If Yes, Give Yeer or Deter	s:		1☐ Yes 2 X No	Specify:			Specify: B	lack		
5-0020	natural',		15. Decedent	's Education		16e. Deced	dent's Usuel Occu	petion		16b. Ki	nd of Business	Andustry		
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lan		o Be	Augutus	Mar	tin			Kati	е	Mae	Su	mmers		
Maryland	& DEE	-	19e. Informent's Name/Reletionsh	hlp (Type, Print)		19b. Mailir	ng Address (Stree	et end Number	or Rurel Route N	umber, City o	r Town, Stete,	Zip Code) 21234		
Z	OI 02 00 M		Kathleen Bla	konov								Maryland		
9	Health Hem 27 to	-	20e. Method of Disposition	akeney	20b. P	lece of Dispo	sition (Neme of		Dete		cation - City or			
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Ba	permit. F Departmi Importar any injur		N 2/a las	and MAD	11 -	1	L. Name end Add	ess or recinty	Baltin	nore,	Maryl	and 21202		
_			J. vacor	icia moc	car		M.C. Ma				orth A			
			23a. Part1. Enter the disease, or shock, or heert feilure. List	complications that caus only one ceuse on each	ed the deeth ine.	h. Do not ent	er the mode of dy	/Ing, such es ca	rdiec or respiret	ory errest,		Approximete Intervel Between		
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	/Medical Examiner		Immediate Cause (Finei disease or condition	aci	ite	m	MO car	dia	llation	eveti	an	One day		
			resulting in deeth)	1	Due to (o	r es e consec	quence of):	۸ .	11 1	_				
Н	P # .	Examiner		- h ch	rari	ci à	trial.	fibre	Matic	in		years		
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00			Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Couse (Diseese or Injury		HI	Sb.						years.		
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	0 0 %	SIC	Pert II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying ceuse g	iven In Pert i.	23b.	Did tobacco	use contribut	e to the cause of death?		
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	signed d be del	D	2000	my										
ord	been si should	9	COPI	\					240.	Wes an autoperformed?	osy 24b.	Were autopsy findings avellable prior to		
S	has be	D e			Λ				_			completion of cause of deeth?		
Œ	0 5 0	Completed	ares	1. shot ton	lar	di	00.0			1 ☐ Yes 2	No	1 ☐ Yes 2 No		
of Vital Records,	ician: The certificate rector, pag	0	25. Wes cese referred to medicei	3 - 500		0003	Cy C	26. Plece o	Deeth (Check	only one)				
>	\$ 00	0	examiner? 1 Yes 2 No	Hospitel: 1 Inpa	atient 2	ER/Outpatier	nt 3 DOA	ther	Ing Home 5		6 □Other (Spe	ecify)		
0			27. Manner of Deeth	28e. Dete of Ir	njury Day Year)	28b. Time or injury	f 28c. Inj	ury et	28d. Desc	riba how Inju	y occurred			
jo	ath.	9110	1 Neturel 5 ☐ Pending 2 Accident investig	9	Day (Gai)	mjury		Yes 2 No						
Division	is or Attendir setter death. I Director: At d in by the fu	E	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determi	inad 288. Plece of	Injury - At ho	me, ferm, str	reet, factory, office	9	28f. Local	ion (Street en	d Number or F	Rural Route Number,		
Ö	s effection	Certification:	4 Dittomolog	bulloning,	etc. (Specify	"			Only	, , Own, Oloic	,			
	Hospital or Attending 24 hours efter death. Funeral Director: After stely filled in by the fune	ia i		g Physician: To the bes										
	n 24	edical	one)	Examiner: On the basis end menner		tion end/or in	vestigation, in my	opinion, deeth	occurred et the	time, date end	piece, end du	e to the cause(s)		
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi	Σ	29b. Signeture end title of certifier	1 ~			29c. Licer	nse number		29d. Da	te signed (Mon	th, Dey, Year)		
			Kla ud	U M)		1/3	32111	2	4-	21-	98		
	2	-	30. Neme end eddress of person v	who completed ceuse o	f death (Item	23e) (Type.	Print)	1116						
	9		KASHIBEN	PATRI		310711	LYMA	J PK	DRIVE	BA	7	Md 2/2/1		
	State	e	31. Dete filed (Month, Day, Year)	32. Regis	stra s ngna	10.00	50 000	110						
	Registra	_	APR 2	2 1998	guila !	Javy dson-	Mandale	- 0						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death ELLWOOD, Month **Physician** LEUSCHNER 5:20p.m. /Medical 4a. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Deeth Greater Laurel Hospital Center Laurel Prince Georges 6. Sex 1. MM 2□ F 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 65 Yrs. Director Unknown 09-29-32 Mary Land Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits The Medical Examiner must be notified at Director MD N/A 1X Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? items 23a or 2035 Annapolis Road 21230 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indien, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iter any injury or other treumatic event, the Mexical Examines once. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorcad Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) unknown Unknown 10 17. Fether'e Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ben A. Leuschner 2 Amelia Johnson 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Francis Leuschner/Brother 2035 Annapolis Rd., Baltimore, MD 21230 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory 4-20-98 Baltimore, MD 4 ☐ Donetion · 5 ☐ Other (Specify) of Funeral Sa 22. Name end Address of Fecility CAFA - Stephen D. Lohrmann, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate shock, or heart feiture. List only one cause on each line.

8717 Green Pastures Dr., Baltimore, MD21286

Approximate intervel Between the shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical HYDOXIA. tmmediete Ceuse (Finel 48 18 diseese or condition resulting in deeth) Examiner Examiner Porain death. 24-48145 sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) attending physician for use as the buria Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dulmonary should be det P 24b. Were eutopsy findings aveilebie prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 s 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Certification: To 1 inpatient 2 ER/Outpetient 3 DOA this funeral 28c. fnjury et Work? 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Neturel s after death. 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide 24 hours Hospital Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 29a. Certifier pietely (Check only one) Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated. To the I within 2 To the I complet 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) 042580 NIL 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5632 Annapolis S. AUJLA.MD

State Registrar

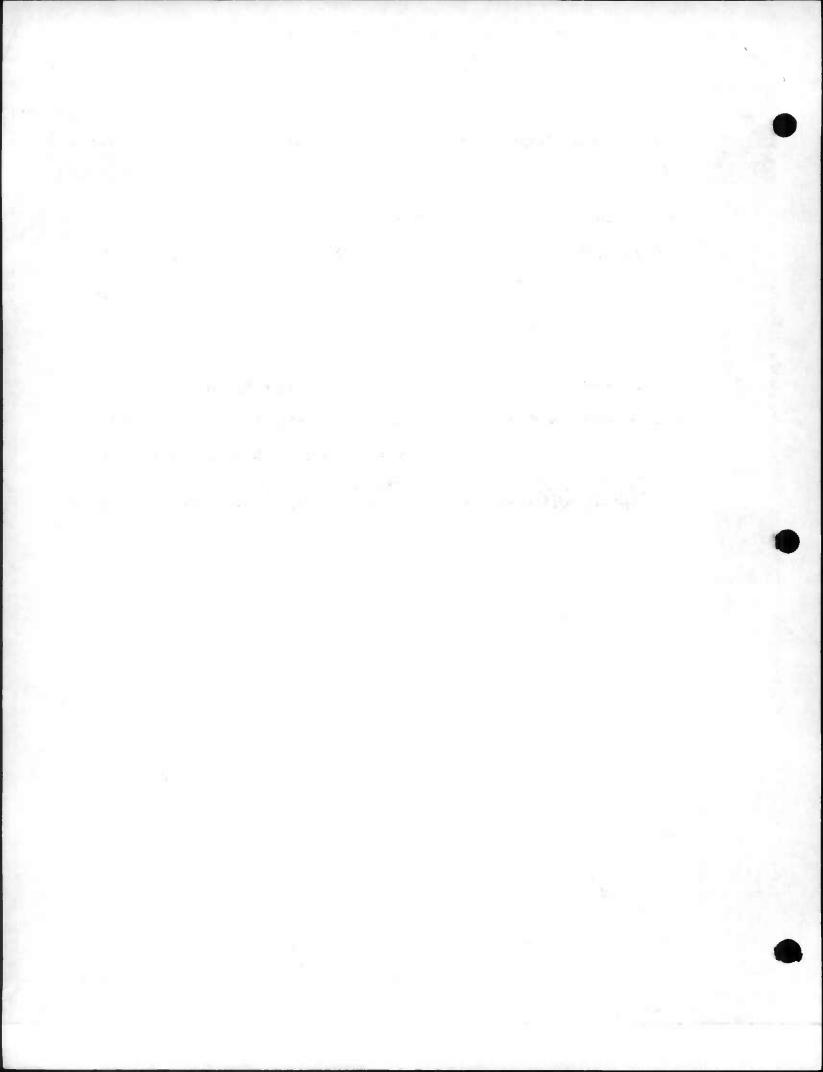
31. Dete filed (Month, Day, Year) APR 2 0 1998

ø32. Registrar's Signeture who Davidson-Randelle

P.O. Box 68760.

Records,

Division of Vital



State of Maryland / Department of Health and Mental Hygiene 98

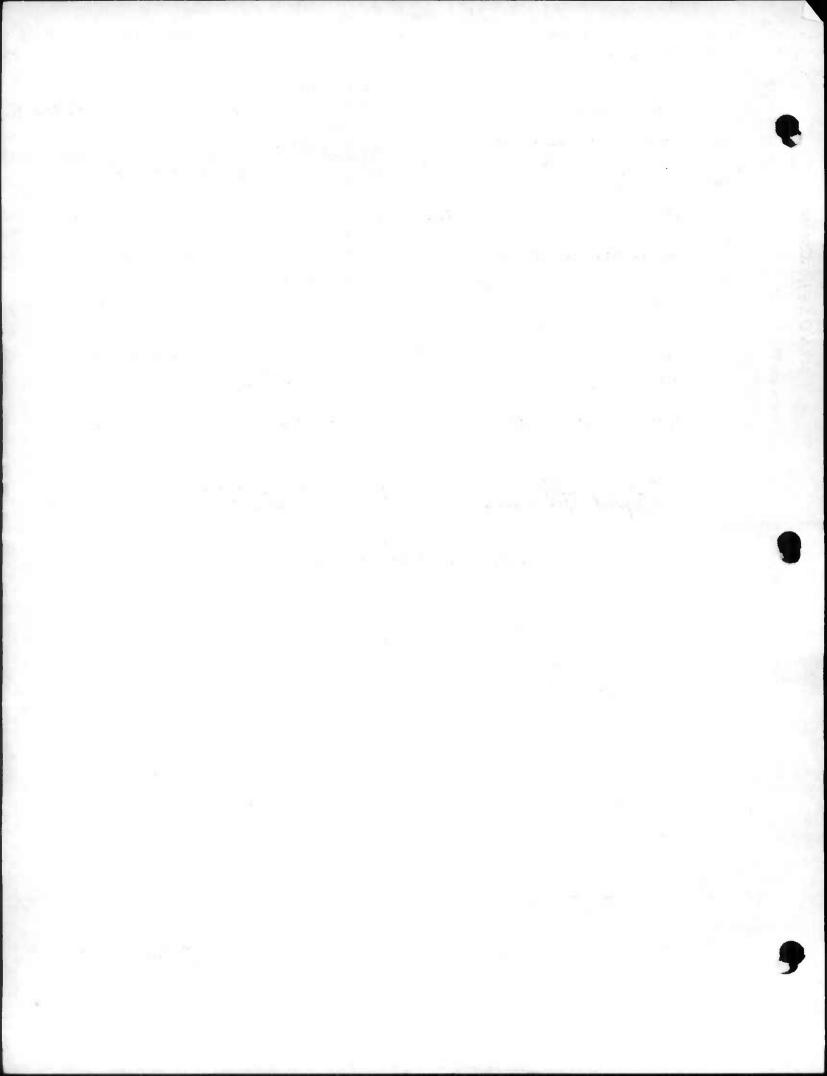
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						Cei	rtificate o	f Death		Reg. No.) (1002
п	Physic	ian	1. Decedent's Neme (First, Middle	, Last)					2. Date of D		Year	3. Tima of Death
	/Medi		John Lee Linds	ay					APRIL	18.1	998	8:454
	Exami		4a. Fecility Neme (If not institution		-			4b. City, Town, o	or Location of Dea	th 4c. Count	of Death	
1			Stella Maris H		Mercy			Baltim		N/I	A	
1	Funeral Director		5. Social Security Number 214-05-5052	6. Sex 7. 1 M M 2 □ F	Age (In yrs. I	78 Yrs.	If Under 1 Yes Months Day		in. 8. Dete of B (Month, D July 2	irth Pay, Year) 28,1919	9. Birthplace Country Unknow	e (State or Foreign) VN
	pur *		Usual Residenca of Decedent 10a. Stete 10b. County		10c City	y. Town or Lo	antion				404	Leader Obert Link
	Maryla -I sho	tor	MD N/A			ltimor					100	No. inside City Limits.
	r 28s	Lec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	n
	h wit	O E	311 Cathedral	Street, A	pt. 2D)	2120	1		United	States	5
	O iffer death with the Main r items 23s or 28s-1 s inter must be notified Funeral Director		11. Marital Status	12. Wes Decede	nt Ever in U,	S. 13.	Was Decedent o	f Hispenic Origin? Iban, Mexican, Pu	(Specify Yes or N		ce - American	Indian,
5-0020 72 hours after death with the Maryland neturel; or items 23s or 28s-1 show sized Examiner must be notified at	by	1 Never Merried 2 Merri	If Yes, Give	1 ☐ Yes 2 🔼 No			o Specity:	erto Hican, etc.)				
0-10	2 hours satural Eral E		15. Decadent	's Education		16a. Deced	dent's Usual Occ	upation	II NOCE	16b. Kind of B	usiness/Indus	stry
21	d 21215-0020 filed within 72 hours af thygiene. then "natural", or not, the Mexical Eventhal	Completed	(Specify only highes Elementary/Secondary (0-12)	T	Collega (1-4or 5+)				vorking			
21		100	Unknown			Foren	nan			Bevera	ctory	
Maryland 2 nd 2 should be filed the and Mental Hygi 77 Is merked other Traumatic event, I	To Be	17. Father's Name (First, Middle, I (Unknown) Lind	*				18. Mother's N		9. Birthplace (State or Foreig Country) 108, 1919 10d. Inside City Limits 10g. Citizen of Whet Country? United States 14. Race - American Indian, Bleck, White, etc. Specify: Black 16b. Kind of Business/Industry Beverage Factory 16, Maiden Sumeme) 16ber, City or Town, Stata, Zip Coda) 17more, MD 21202 20c. Location - City or Town, State Baltimore, MD 17mn, P.A. Baltimore, MD 21286 Approximate Interval Between Onset and Deeth			
and	laryla 2 should and Men le merke sumetic		19a. Informant's Name/Relations!			19b. Mailir	ng Addrass (Stre	et end Number or	Rural Route Num	ber, City or Town	, Stata, Zip Co	oda)
	Health Health tam 27 I		Levern Corbert	/Friend				od Avenu	e, Balti	more, M	21202	>
ore	of He		20e. Method of Disposition 1 Disposition	2 Demousl from Ste	Ce	ematary, cren	sition (Neme of netory or other p	lece)	Deta			
3	Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If fine 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Marical Examiner must be not fled at once.		4 Donetion 5 Other (Sp		Gr	een Mo	unt Cre	matory	4-22-98	Baltimo	ore, MI)
Balt			21. Signalario al Europea Libervica I	lunam		C	AFA - S	tephen D	. Lohrma	nn, P.A.		
	Physician /Medical Examiner	er	Immadiata Cause (Final disease or condition resulting in death)	a TERMIN	VAL Due to (or	HEAR T	TFAILL					
	nsit	들		. DEM	ENTIA	\						
,	tificate be executed g physician and as the burial-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			ras a conseq				į		
68760,	e be rsicia		that initiated evants	c. SEVE			STENOS IS	5				
	g phy as th	Ped	resulting in death) Lest		D09 t0 (01	as a conseq	uence or):				1	
Box	eath cert attandin for use	N/UE	'	d								
	death	Sicia	Part II. Other significant condition	ns contributing to death	but not resu	ulting In the ur	nderlylna causa	oiven in Part I.	23b. Dio	tobacco use co	ontribute to th	e cause of death?
s, P.O	as that the de igned by that be detached	by Physician/Medical										
Records,	requir been s should	Completed t									evaile	ble prior to
æ	0 4 8	E							1	Yes 20 No	1 🗆 Y	
Vital	lclan: Th certificata rector, pa	Be C	25. Was case referred to medical					26. Place of D	Death (Check only	one)		
f <	5 00 5	ToE	examiner? 1 Yes 2 No	Hospital: 1 Inpa	itient 2 🗆 I	ER/Outpatien	t 3 DOA	other: 42 Nursing	Home 5 Res	MARIS sidence 6 Ott	er (Specify)	CE
1 of	ding Ph. h. After thi funaral		27. Manyler of Death	28a. Date of Ir		28b. Tima of Injury			7	how Injury occur		
0	Attending ir death. ector: After by the funa	atlo	1 2 Natural 5 Pending 2 Accident Investig	ation	July Foully	прагу		☐ Yes 2 ☐ No				
Division	al or Atte s after de i Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicida datarmi	and Zee. Place of I	njury - At ho atc. (Specify	ma, farm, str	eat, fectory, offic	lectory, offica 28f. Location (Straet and Number or Rurel Received for Town, Stete)				
	To the Hospital or / within 24 hours after To the Funeral Direct completely filled in b	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best examiner: On the basis and mannar	of examinati	vledge, death ion and/or Inv	occurred at the restigation, in my	time, date and pla opinion, deeth oc	ca, and due to the curred at tha time	a cause(s) and m , data and placa,	anner as state and due to th	e cause(s)
	To the Within To the	Me	29b. Signatura and title of cartifier				29c. Lice	nse number		29d. Date signe	ed (Month, De	y, Yeer)
	0		> 32	Dam			1	20480		APRIL	18,19	98
			30. Nama and address of person v		death (Itam		Print)	040480 0672 B Balto	KLB .	2/231	5	

Registrar

State

LINDSAY, JOHN

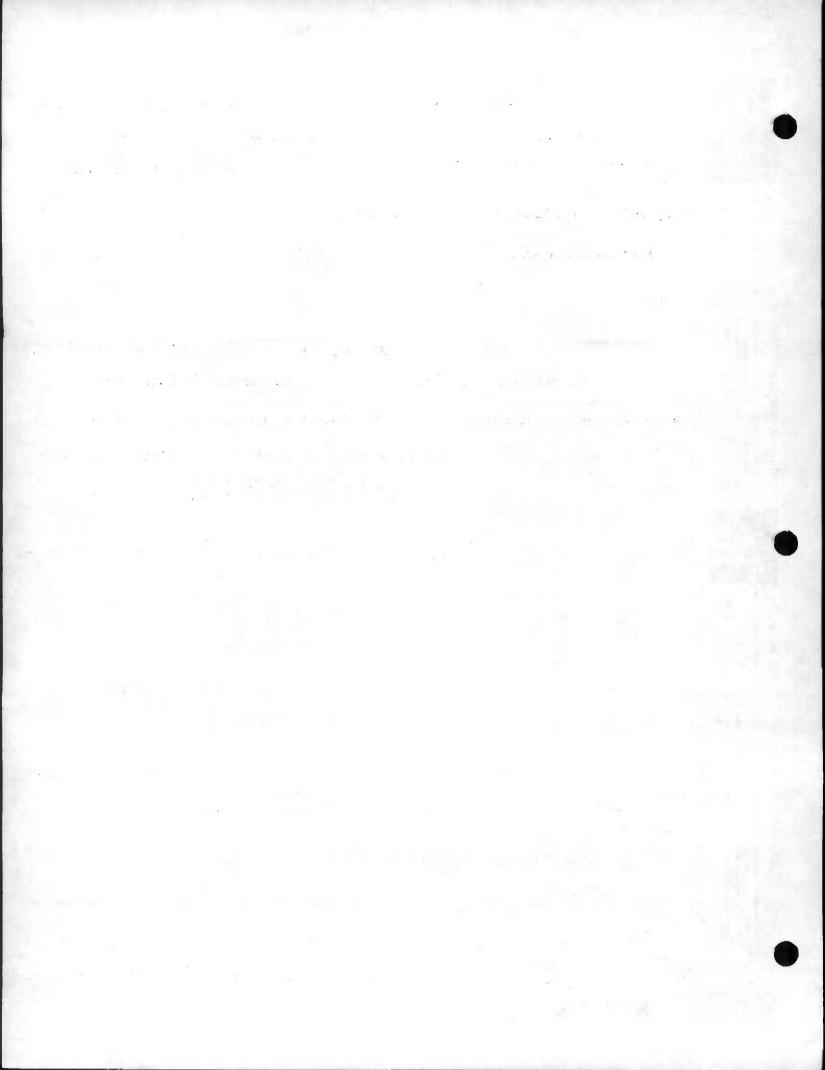


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98-2160-510 KIANA	Please I	'ype or Print In Blac State of Maryland / I			•		10000
McGEE	Items: 23 part I,27,28a. 1. Decedent's Nama (First, Middle, Last)	f non MEO C 750 5/1	Certificate of	Death	Reg. N	20	12653
	1. Decedant's Nama (First, Middla, Last)	-1 per Meu G-759 5/1	1/98		2. Data of Death	ay Yaa	3. Time of Deeth
Physician /Medical	Kiana	y. (Y	1c Gee		APRIL 17,		9:24 PM.
Examiner	4a Facility Nama (If not Institution, give s LIBERTY MEDICAL			4b. City, Town, or Loc BALTIM		lc. County of De	eath
Funeral Director	5. Social Security Number 6. Sax 217 - 92 - 9687	7. Aga (In yrs. last bi	rthday) If Under 1 Year Yrs. Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Yea	9. F	Birthpiaca (Stata or Foreign Country)
D.	Usual Rasidance of Decedant 10a. Stata 10b. County	10c. City, Tow	n or Location		1004 0,1		10d. Insida City Limits
ore, Maryland 21215-0020 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The salth and Mental Hygiene. The marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Healthal Eventine must be notified at To Be Completed by Funeral Director.	1	B	altimo	re	10g. C	Citizen of What	¥Yas 2□No
ath with 23a o	2827 Westw	good Avenu	e 21	216		U.S.	A.
a 28 5	11. Marital Status 1 Navar Marriad 2 Married	12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No	13. Was Decedant of H		cify Yas or No- lican, atc.)	Black, W	marican Indian, hita, atc.
002 hours e urel', o	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:	1 Yas 2 No		4.01	Specify:	slach
od within 72 hours after yoydene. The Healing Every of the Healing Every of the Completed by Fur	15. Decedant's Educ (Specify only highast grada		Giva kind of work dona lifa. DO NOT usa ratire	petion during most of working d)	g 16b.	Kind of Busines	ss/Industry
id 212 filed withi Hygiene. out, me H	Elamantery/Secondary (0-12)	Pa	ira Pro-	essiona			more City
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours att begarnent of Health and Mental Hyghersham mortant: If fem 27 is marked other than "natural", or my injury or other traumatic event, the Health Event and Injury or other traumatic event and Injury or other e		Chew		Karer	n R. 1	ncG	ee
e, Maritand 2 should be sh	19e. Informant's Name/Ralationship (Type	oa, Print) 191 DWN 5	b. Mailing Addrass (Stream)	0	enue Ba	Itimo	- M. / lan
imore, Pages 1 a nent of Her nt: if item iry or othe	20a. Mathod of Disposition 1 Burial 2 Cramation 3 Re	20b. Place o	of Disposition (Nama of ry, cramatory or other pla			Location - City	
Baltimo	4 □ Donation 5 □ Other (Specify)	Hrb	rutus Memo	orial lack 4	-24-98 E	altin	nore Marylan
Balti pemit. I Departm Importa any Inju	21. Signature of Funaral Sarvice Licensa	"DR. L.	Joseph -	H. Brown	/ 1 1 1 4		ome, PA.
	23a. Fart1. Entar tha disaasa, or comption shock, or haart failura. List only on	cations that causad the death. Do	not antar tha moda ot dyi		respiretory errest.	ore Mari	Approximete Interval Batwaen
Physician /Medical	Immadiata Causa (Final disaasa or condition	STRANGULATION					Onsat and Death
Examiner	rasulting in daath)	Due to (or es e	consequence of):				
secured transit	Sequantially list conditions,	Due to (or as a	consequence of):				
A C S III	if any, laading to Immadiata causa. Enter Undarlying Ceusa (Diseasa or injury c.						
18 Physical Redice	that initiated avants rasulting in death) Last	Dua to (or as a	consequance of):				
Sox in cert	d						
P.O. Box 6876 that the death certificant be ed by the attending physical detached for use as the bu	Part II. Other significant conditions cont	tributing to death but not resulting I	in the underlying causa gi	van in Part I.	7		ute to the cause of death?
IS, P.					1 Tes	2□ No 3□	Probably 4.⊠Unknown
k requir been a should					24a. Was an au performed?	opsy 24	b. Wara autopsy findings avallebla prior to complation of causa of death?
Vital Rec	71				1.80 Yes	2 🗆 No	12 Yes 2□ No
Vita ician: pertific rector,	25. Was casa rafarrad to medical axaminar?	ospital:	Ott	26. Place of Death			
on of Name of Alberthis of funeral din	Mannar of Deeth	1 Inpatient 2 MER/O	utpatient 3 DOA Tima of 28c. Injury	4 La Nuising Hom	a 5 Rasidance 8d. Dascribe how in		pecify)
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Division (bit or Attending P is after death. all Directors Alter to led in by the fumer certification:	3 ☐ Sulcide 6 ☐ Could not be datarminad	28a. Place of Injury - At homa, for building, atc. (Specify)	arm, straat, factory, office	2	8f. Location (Straat City or Town, Sta	and Number or	Rural Routa Number, estwood Ave.
political courses ours as a life of	29e, Cartifiar 1 ☐ Certifying Phys	home Iclan: To the best of my knowledge	e deeth occurred at the ti	me, date end plece, er	Balti	more, Md	•
To the Hospital within 24 hours a To the Funeral I completely litted		er: On the basis of axamination er and manner stated.					
To the within To the comp	29b. Signatura and titla of certifiar	. 1	29c. Licans	sa number			onth, Day, Year)
	30. Nama and eddrass of person who con	Vuela	MP	.F1. E.	AP	RIL 18,	T330
			Penn Stree	t, Baltimo	re, Maryl	and 212	01
State	31. Data filed (Month, Day, Year) APR 9 1000	32 Fedutrar's Signatura	Randell				
· Registrar	MED VY UIR	and their first of a					

and programmy cars.

State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death

							OUI	imouto of	Doutin			Heg. No.			
Physician	1. Deced	ient's Name) (First, Middle		Rose I	. Mill				2. Dete of De Month April	Dey 17,1998	Year	3. Time of Deeth 6:15 a.m.		
' /Medical Examiner	4e Fecil	ty Neme (If	not institution	, give street e	nd number	7)			4b. City, To	wn, or Lo	cation of Deet				
LAGITITICI			odlawn						Pasa	dena		Anne	Aru	ndel	
Funeral	5. Sociel	Security No	umber	6. Sex	7. A	ge (In yrs. lest	birthday)	if Under 1 Yea	ar If Under a	24 Hrs.	8. Dete of Bir (Month, De	th	g. Birth	place (Stete or Foreign ntry)	
Director		20-470		1□M 2	Ø F	73	Yrs.	Months Dey	s Hours	Min.	Jan. 1	2,1925	Mar	ryland	
- M	10e. Ste		10b. County			10c. City, T	own or Loc	ation					T	10d. Inside City Limits	
2 should be filed within 12 hours effer death with the Merylend 15 marked other than "nature!", or items 23s or 28s-1 show reumatic event, the Mexical Examiner must be notified at To Be Completed by Funeral Director	Mary	land	Ann	e Arund	del		Pa	asadena			1 ☐ Yes 2 🖺 No				
288	10e. Stre	et end Nun	nber					10f. Zip Code)			10g. Citizen of Whet Country?			
D Di		1103	ic [boots	wn Ave					21122		U.S.A.				
ma 2	11. Marit	ei Status	Woodia			t Ever in U.S.	13. V	Ves Decedent of		gin? (Spe	ecify Yes or No			can Indien,	
ritems 23s or 28s-1e riner must be noutled Funeral Director	101		ed 2 Marr	ied 1 🗆	ed Forces Yes 2 ∑	If Yes, specify Cuban, Mexican, Puerties 2 ⊠ No							k, White,		
ist, or items 23s or 28s-f show Examiner must be notified at by Funeral Director	3⊠	Nidowed	4 Divorced	if Y	es, Give er or Detes		1	☐ Yes 2⊠N	o Specify:			Specify	. Wh:	ite	
ygiene. her than "naturel", o nt, tre Mexical Exart Completed by		10	15. Decedent		4 0	1	6e. Deced	ent's Usuel Occ	upetion			16b. Kind of Bu	siness/Ir	ndustry	
Me."	Fleme		ndary (0-12)	t grede comp	lege (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)								
on the		8			N/A	.,	P	BX Oper	ater			Marylan	d Ger	neral Hosp.	
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arked atic e				Regin	ald	Breede	n		Ca	athe:	rine S	hallenberger			
other traumatic event, tra Maulcal To Be Completed		oment's Na	me/Relations	hip (Type, Prir	nt)	1	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zi						p Code)		
ther tra	Susa	an Bec	kner	Da	ughte					. Pa	Pasadena, Maryland 21122				
item 27 other to		hod of Disp				20b. Place ceme	e of Dispos	sition (Name of natory or other p	lece)		Dete	20c. Location -	City or T	own, Stete	
Department of Important; if it any injury or o			□ Cremetion 5 □ Other (S)	3 □Remova pecify)	from State	A				ril	21,199	8 Baltin	ore,	Maryland	
	21. Sign	ature of Fur	neral Service	Licensee	D /		22	Name end Add	ress of Fecilit	у					
	McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryl											and	21122		
	2 m 2	rt1 Enter th	e disease or	complications	that cause	of the death [-	or the mode of d					and	Approximate	
lalan	sh	ock, or heer	t feilure. List	only one ceus	e on each	line.								Interval Between Onset and Deeth	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** FRANCES MCCLENON 10:15pm 498 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BACTIMORE STELLA MARIS @ MERCY HOSpital Hours Min. 8. Date of Birth (Month, Pey, 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 20/F 217-20-4705 Yrs. Director Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or flems 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at BALTIMORE N/a Yes 2□No MID Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Koad 21215 PinLico 4015 U.S by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X☐ No ff Yes, Give' Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BL/C 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL HOUSE KEEPER -0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be HERMAN MEARS ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BACTIMORE, MD. 21215 4015 Pinlico Rd. MC CLENON Important: If Itam 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Pate 1 Burial 2 ☐ Cremation 3 ☐ Removel from State GARRISON FOREST OWINGS MILK, MU 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility E. L. PHILLIPS FUNERAL HOME. 1721-27 N. MOMA ST. BALTIMORE, MD. 21219 CFSP Decla etha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medicai Immediate Cause (Finel CHARCER METASTATIC OVAMINA 4 glass disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown sign be þ 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy completion of ceuse of deeth? page 2 1 ☐ Yes 28 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) STELLA MARIS AT MERCY Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) OSPICE 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Matural s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D 29a. Certifier Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) mono D40480 30000 7672 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print) Ferro, mo 21236 32 Registrar Signeture

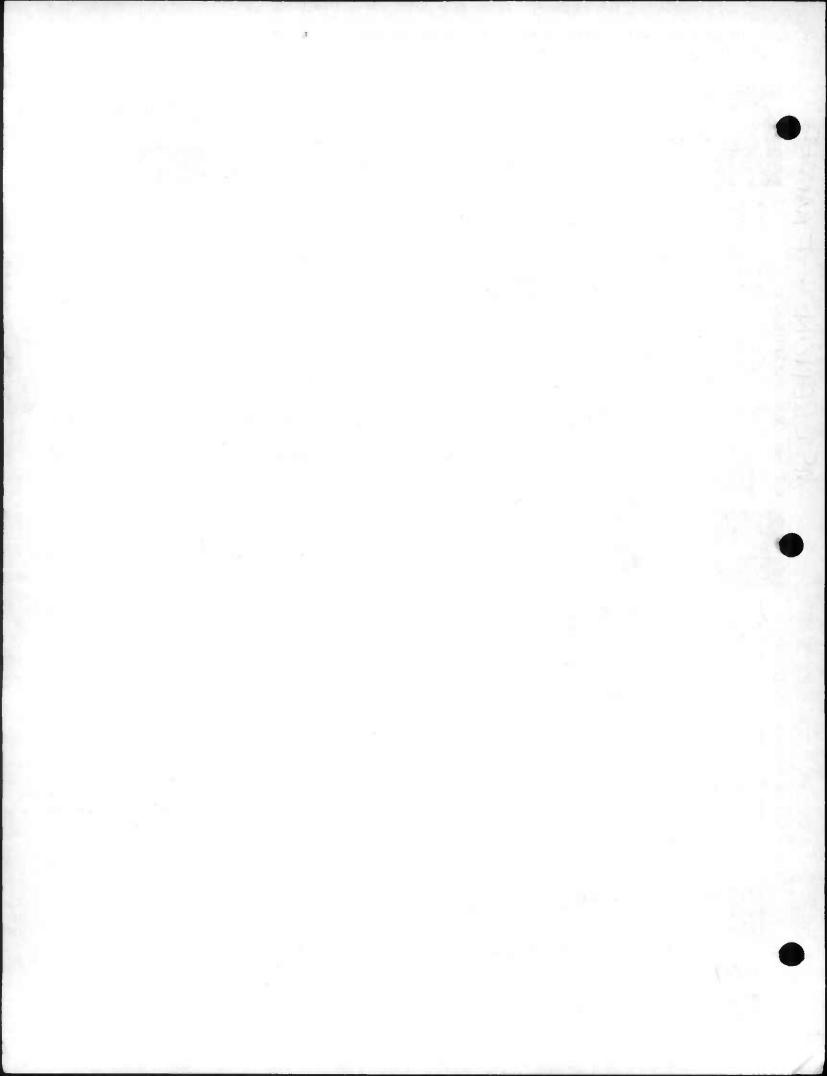
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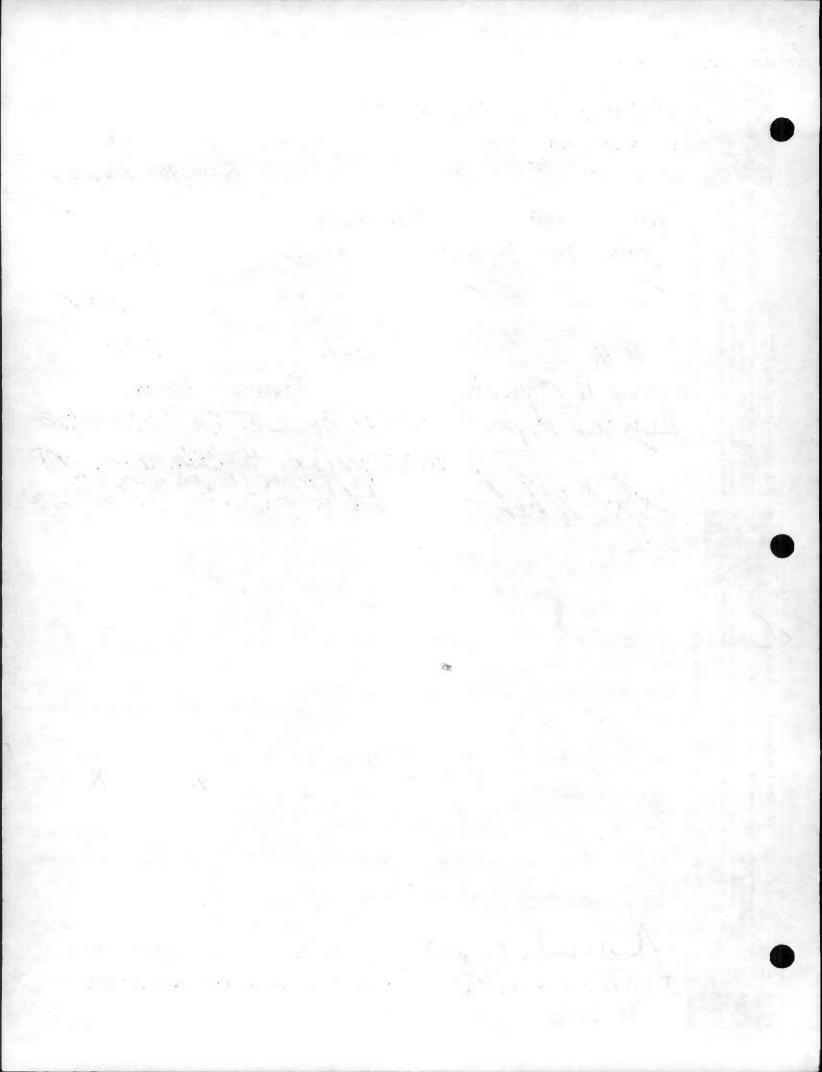


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111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signatura

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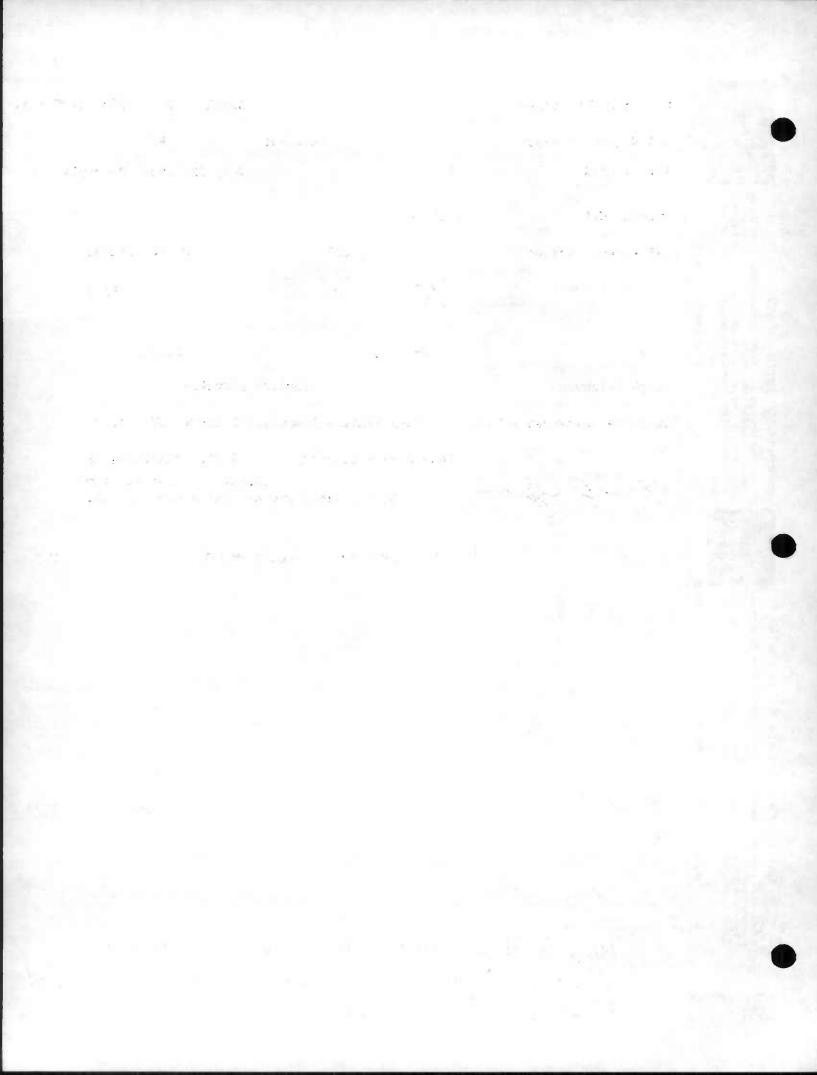


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Dete of Death Month April **Physician** 20 Eugene P. Melcavage 1998 2:00 p.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore 825 Hollins Street 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Months 1₽M 2□ F Days Hours Min Yrs 217-24-0178 67 July 22, 1930 Director Pennsylvania Usuel Residence of Decedent the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at N/A 1 TYes 2 No Maryland Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2695 Wilkens Avenue 21223 United States 8 death Funer 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 1951 — If Yes, Give Year or Dates: 1953 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status nit. Pages 1 end 2 should be filed within 72 hours after of erment of Health and Mentel Hygiene.
ortant: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examine. 1 ☐ Never Married 2 N Married White 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorcad Completed 16a. Dacedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) College (1-4or 5+) Foreman Steel 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Melcavage Pauline Ajauskas 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine Melcavage / Wife 2695 Wilkens Avenue, Baltimore, MD 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Depertment of Important: If any Injury or 4/23/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Servi 3620 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) ACUTE MYELOID LEUKEMIA

Due to (or as a consequence of): Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Undarfying Cause (Disaase or Injury that Initiated avants rasulting In daath) Last Due to (or as e consequence of): certificate be exec Box 68760 Physician/Medical Due to (or as a consequence of): esn P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, P 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? has 214 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Plece of Death (Check only one) Hospital: SISTERS 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending 1 | Yas 2 | No deeth. investigation 2 Accident or Attancattan desti 6 Could not be datarmined 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 - Homicida 29a. Cartifiar (Check only one) 15/certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated. Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and mannar stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14(1.) of person who completed cause of death (Item 23e) (Type, Print) 30. Neme end eddrass 2126 YMAN M.D UNIVOFMD HOSP 22 SGREENEST BACTO

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** DON **McMASTER** April 20, 1998 9:40 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meridian - Hamilton Nursing Home Baltimore City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Yrs. 325-12-5280 Director June 25,1921 Illinois Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23s or 28s-f show yillury or other traumatic event, the Modical Exercises must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1 Yes 2 □ No Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3410 E. Northern Parkway 21206 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) Coilege (1-4or 5+) U.S. Coast Guard U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul McMaster Virginia Vanderwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3034 Westfield Avenue Mr. Robert S. Duraczyk - Cousin Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/24/98 Holy Redeemer Baltimore.MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland Leonard J. Ruck, Inc. 5305 |
23a. Pert1. Enter the disease, or complications if at aused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart failure. List only one causing a such line. 5305 Harford Rd Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Intracranial Examiner Due to (or as a consequence of): Physician/Medical Examine Cercs rovasanla Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be exect Hypertansin Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) 98 1 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Ś 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b irector, page 2 s 1 Tyes 2 No 1 Yes 29 No or Attanding Physician: 25. Was cese referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28c. injury at Work? Certification: 1 PNeturel 5 Pending investigation 1 TYes 2 No Euneral Director: A Funeral Director: A pletely filled in by the funeral parts of the fu death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner es stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

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Registrar

31. Date filed (Month, Dey, Yeer) APR 2 2 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOANT A. HASHMI, 821 N. ENTAW 32. Registrar's Signature whice Drugdson

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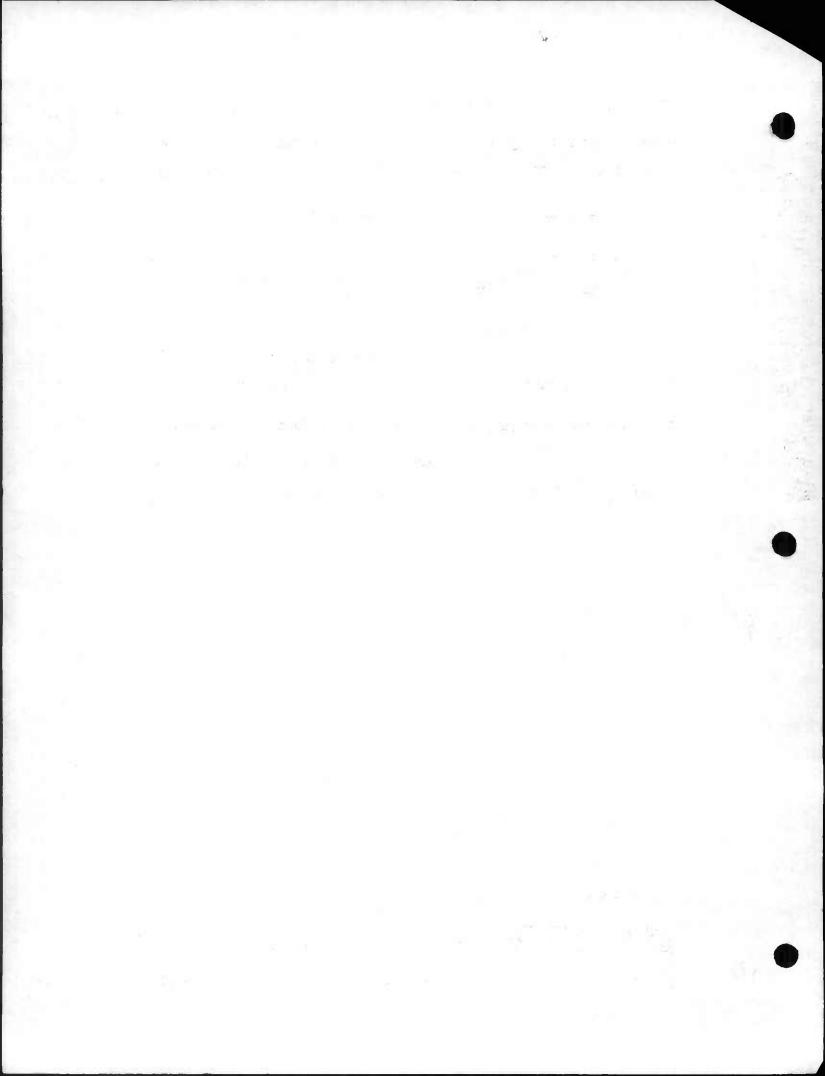
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540	H there		20e. Method of Disposition 1 ☑Surial 2 ☐ Cramation 3 ☐	Removel from State	20b. Pia	aca of Dispo	sition (Nem	e of har plea	ce)	Date	20c. Location	- City or To	wn, Stata		
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	Withir To th	Me	29b. Signature and title of centur	1	29d. Dala sign	ed (Month,	Day, Year)								
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	10		30. Name end address of person who co	completed cause of d	leeth (Item :	23e) (Type, I	Print) 33 H	e.	1 Kng	DV	Post	in	1000	481	
	Sta Registr		31. Dete tiled (Month, Day, Year) APR 2 2 1	32. Ragistr	cha Sau	rdson-1	andell								



State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 2. Data of Death 3. Tima of Death

Physician /Medical Examiner

Funeral Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Hauth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, in a Marijani Examiner man be notified as

Baltimore, Maryland 21215-0020

Physician /Medical Examine

been signed by should be detac this cartificate funeral director,

Affer

i or Attending after death.

To the Hospital of within 24 hours a To the Funeral D 24 hours

Division of Vital Records,

HOOKE.

1. Decedent's Nama (First, Middla, Last) Month Year ALFRED G. MOORE 4:15 Am. 21 1998 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A ST. AGNES HEALTHCARE If Under 24 Hrs. 8. Data of Birth Month, Dev. Year MAR. 15, 1910 MARYLAND 6. Sex. 1 ☑ M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foraign Days 213-09-6036 88 Yrs. Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MARYLAND BALTIMORE LANSDOWNE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2005 HAMMONDS FERRY ROAD 21227 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) FOREMAN WOOLEN MILL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) DANIEL WEBSTER MOORE KATHERINE WILES 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 7950 PIPERS PATH, GLEN BURNIE, MARYLAND 21061 RICHARD MOORE, SON 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata GOOD SHEPHERD CEMETERY 4/24/98 ELLICOTT CITY, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility WITZKE FUNERAL HOMES, INC. 21. Signatura of Funaral Sarvice Licenses Rel 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final PNEUMONIA disaasa or condition rasulting in daath) DAYS Dua to (or as a consequence of): Examiner YEARS CORONARY ARTERY DIS EASE Sequentielly list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): DAYS CEREBROVASEULAR ACCIDENT Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 Tyes 2 No þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of causa of daeth? 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to medice! 26. Placa of Daath (Check only ona) axaminar? Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☑ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. injury at Work? 1 DNatural 5 Pending 1 Yas 2 No Invastigation 2 Accidant 3 Suicida

6 Could not be 26f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homlcida 15 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) 29a. Certiflar and manner stated. 29b. Signatura and proof certifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

APRIL 21, 1998

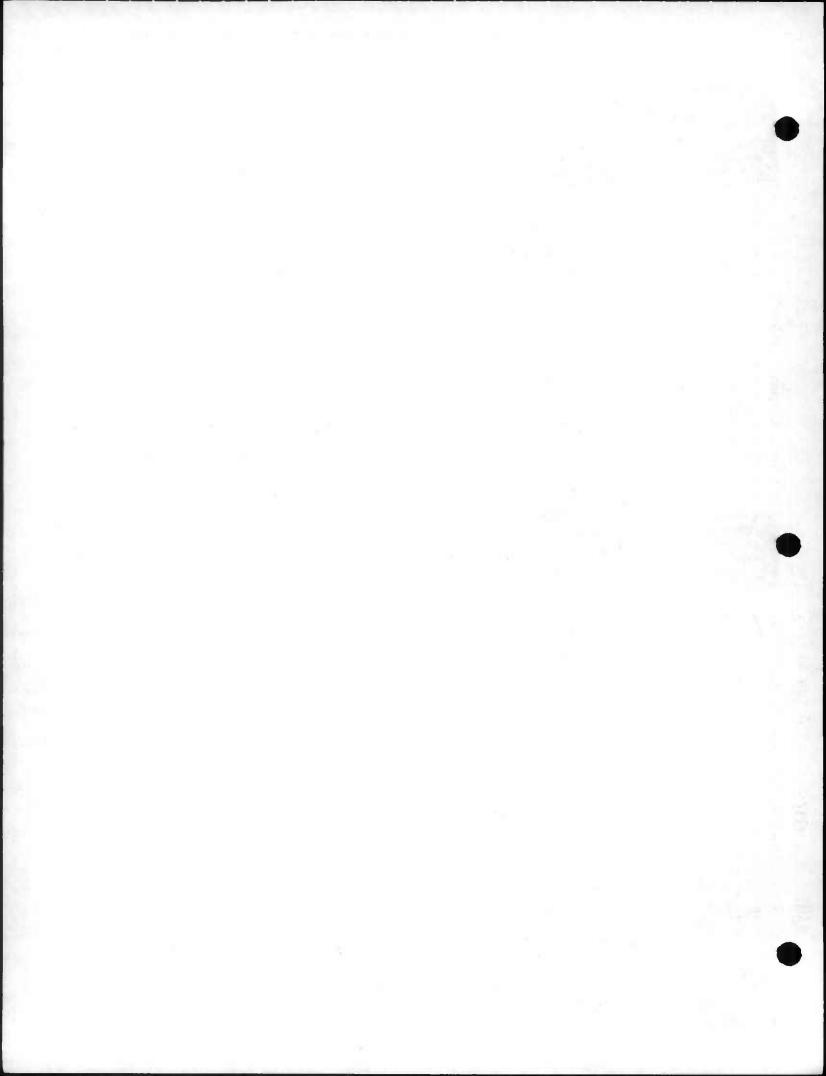
mp 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)

CATON AVE, BALTIMORE, MD, 21244. GHANI, M.D. 900 31. Data filed (Month, Day Year) APR 2 2 1998 32. Ragistrar Signature

Q Suna Davidson-Randsse

State Registrar

edicai



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath APRIL Day 15, 1998 0650 MORRISEY **EUGENIA** Α. 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death BALTIMORE MEDICAL CENTER MERCY 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year if Undar 24 Hrs. 9. Birthplece (Stete or Foreign 7. Age (In vrs. lest birthday) 1 M 2 F Months Devs Hours BALTIMORE, MD Yrs. 1946 JUNE 5, 51 218-44-7117 Usual Rasidanca of Dacedant 10a. Stete 10b County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 No MARYLAND BALTIMORE (RANDALLSTOWN) BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7013 RUDISILL COURT APT 2-A 21244 **USA** 12. Was Dacadant Evar in U,S. Armed Forcas? 1 Yas 2 N No If Yas, Give Year or Detes: 13. Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, Whita, atc. 1 Nevar Married 2 Merried Specify: AFRO. AMERICAN 1 Yas 2 No Specify: 3 Widowad 4 Divorcad 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highest grada complated) Collega (1-4or 5+) Elemantary/Secondary (0-12) UNIVERSITY OF MARYLAND FINANCIAL SERVICE 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) ANDERSON **ANDERSON** REBECCA **EUGENE** 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 313 W. GARRISON BLVD, BALTIMORE, MARYLAND 21215 MORRISEY HUSBAND SYLVESTER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) CEDAR HILL CEMETERY 4/21/98 BROOKLYN, MARYLAND 21. Signature of Funerel Servica Licansee ESTEP BROTHERS FUNERAL HOME, P.A. LLOYD M. ESTEP BROTHERS FUNERAL HOME, 1300 EUTAW PLACE, BALTIMORE, Pert1. Ent. Ith. isease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. LLOYD 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximete Interval Batween Onset end Death Immediata Causa (Final disaasa or condition resulting in deeth) Morbid Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In daeth) Lest Tymors Droid Due to (or es e consequança of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yee 20 No 24b. Wara autopsy findings evailable prior to complation of causa of death? 24e. Was en eutopsy performad? 1 X Yas 2 □ No 1 ☐ Yes 2 💢 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Tima of 28d. Dascribe how injury occurred

28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Dey, Year)

APRIL 15, 1998

Physician /Medical Examiner

permit. Pagas Department of Important: If it eny injury or o

Physician

/Medical

Examiner

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Funeral

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Completed

12

Funeral

Director

Pagas 1 and 2 should be filed within 72 hours after deeth with the Menyland and neather byglene. and of health and Mantel byglene. In: If them 27 is marked other than "nature!", or items 23s or 28s-f show my or other traumatic event, the Medical Evanture, must be notified at my or other traumatic event, the Medical Evanture, must be notified as

Examiner physician and s the burial-transit Physician/Medical 88 US6 ò Completed

Be

Certification: To

edical

1 Natural 2 Accidant

3 Suicida

29a. Certifier

4 Homicida

(Check only one)

29b. Signeture end title of certifie

cartificate hes t lirector, page 2 s this

The law requires that the death certificate be asscuted Records, P.O. Box 68760, Division of Vital Attending Physician: Direc ò

> State Registrar

L. HANKINSON ARLENE 31. Data filad (Month, Day, Yaar) APR 2 2 1998

30. Neme and eddress of person who completed cause of daeth (Itam 23a) (Type, Print)

5 Panding invastigation 6 Could not be datarmined

> 301 SAINT PAUL PLACE, BALTIMORE, MARYLAND 21202 32. Registrer's Signature

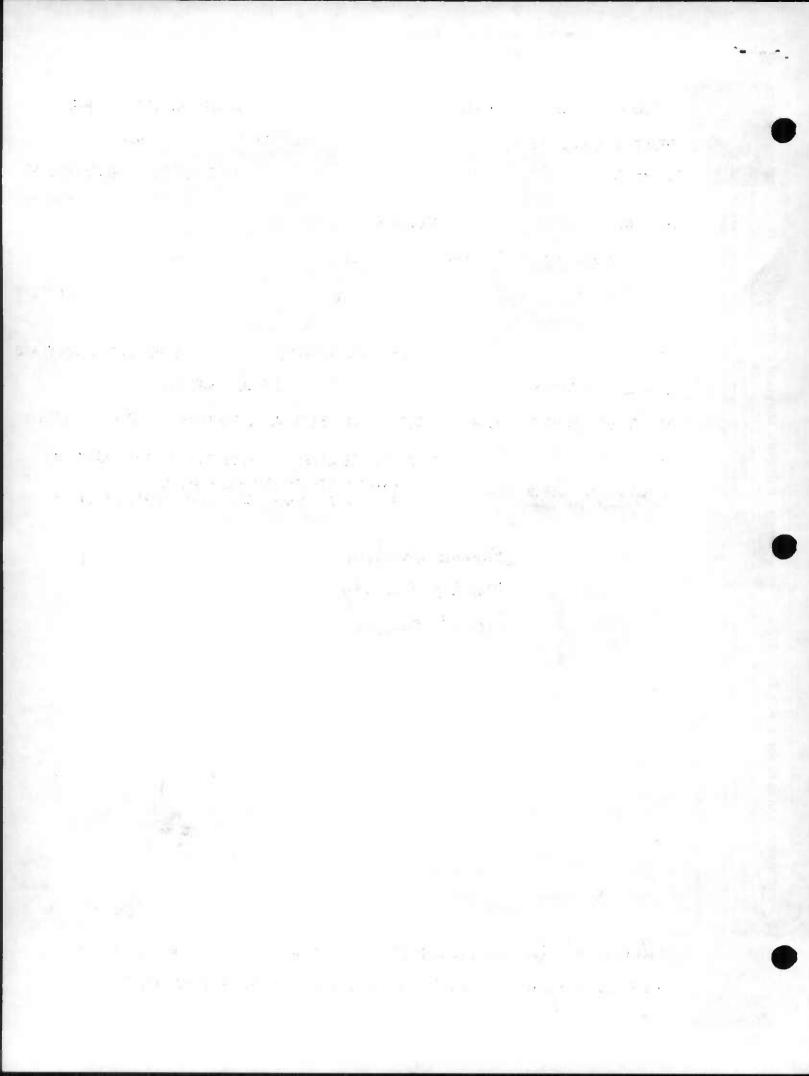
hule Davidson-Pandelle

28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

1 🔀 Certifying Physicien: To tha bast of my knowladga, daath occurred at tha tima, data and placa, and due to tha causa(s) and mannar as steted. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licensa number

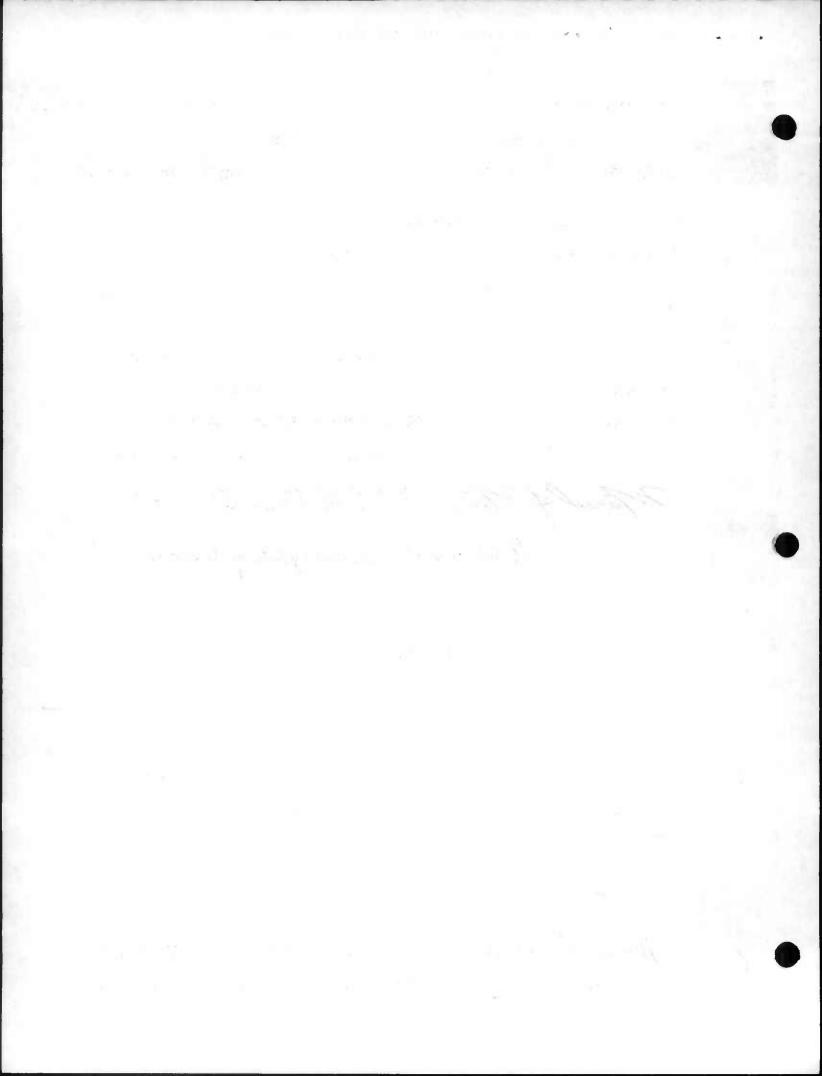
PL 2004



State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 18, ^{Dey} 1998 **Physician** Drue Anita Matassa 12:30 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Canton Harbor Nursing Home **Paltimore** N/A 8. Date of Birth (Month, Day, Ye 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Months Hours 217-22 7220 92 Director July 20, 1905 Balto., Md. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 23a or 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yas 2 No N/A Md. Baltimore 10e. Sfreef and Number 10f. Zip Code 10g. Citizan of What Country? 760 East Fort Avenue 21230 U.S.A. death v Funerai Нете 11 Marifal Status Was Decedanf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whifa, etc. permit. Pages 1 end 2 should be filed within 72 hours efter. Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite, any injury or other traumatic event, me Medical Examina 1 ☐ Yes **2** ☐ No If Yes, Give 1 Never Marriad 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 John Quail **Iavinnia** Thomas 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drue Franck 760 East Fort Ave., Baltimore, Md. 21230 20b. Plece of Disposition (Neme of camatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State Moreland Memorial Park 4-21-98 4 ☐ Donation 5 ☐ Ofher (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Moran-Ashton-Dabrowski- Funeral Home, Inc. 23a Parti. Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Urterioschrotie covenary artery desease /Medical Immediete Cause (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificete be executed ar Pa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760, ettending physician Physician/Medicai thet initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 3 Unknown Records. þ 24b. Were autopsy findings available prior fo completion of causa of death? page 2 should Completed 24a. Was an autopsy performed? certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: Be director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending Investigation 1 Natural death. 1 🗌 Yes 2 🗆 No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide 1 Critfying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es steted.

2 Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely onel 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D21022 repleted cause of death (Item 23a) (Type, Print)
19 8604 HARFORD WO SACTO MD 21234 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Dete of Death 633 Month Year MYRL ORLOWSKI 13 - 98 pm 04 -4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1□M 2□F Months Days 216-09-0629 83 Yrs JULY 13,1914 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits CITY BALTIMORE CITY 1. Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 632 RAPPOLLA STREET 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give 1 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3.☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 7 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) EDGAR WILHELM **ESTHEY** HALE 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) JEAN E. ORLOWSKI/DAUGHTER 632 RAPPOLLA STREET BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/17/98 BALTIMORE, MARYLAND OAK LAWN CEMETERY 21. Signature of Funeral Service Li 22. Name end Address of Fecility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 enter the mode of dying, such as cerdiac or respiratory errest, Approximate isuae, gramplications that caused the death. Do not ente Approximete Intervel Between Onset and Deeth Immediete Ceuse (Final hemorrhage disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident

P.O. Box 6876 The law requires that the death certificate use as Records. 8 this certificata Division of Vital or Attanding Physician: director, funeral After death. s after death filled in by the

þ Completed Be

Medical

Physician/Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

must be notified at

7 is marked other than "naturel", or items treumatic event, the Medical Examiner ma

other

= 0 permit. Page Department of Important: If any Injury or

Physician /Medical

Examiner

i Hygiena.

Pages 1 and 2 should be filed venent of Health and Mental Hygient: If Itam 27 is marked other t

Director

Funeral

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Completed

death with the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

To the Hospital of within 24 hours at To the Funeral D

on who completed ceuse of deeth (Item 23a) (Type, Print) State Registrar

3 Sulcide

29a, Certifier

4 ☐ Homicide

29b. Signature and the of certifier

6 Could not be determined



MU MO/PAD

neurology resident

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner stated.

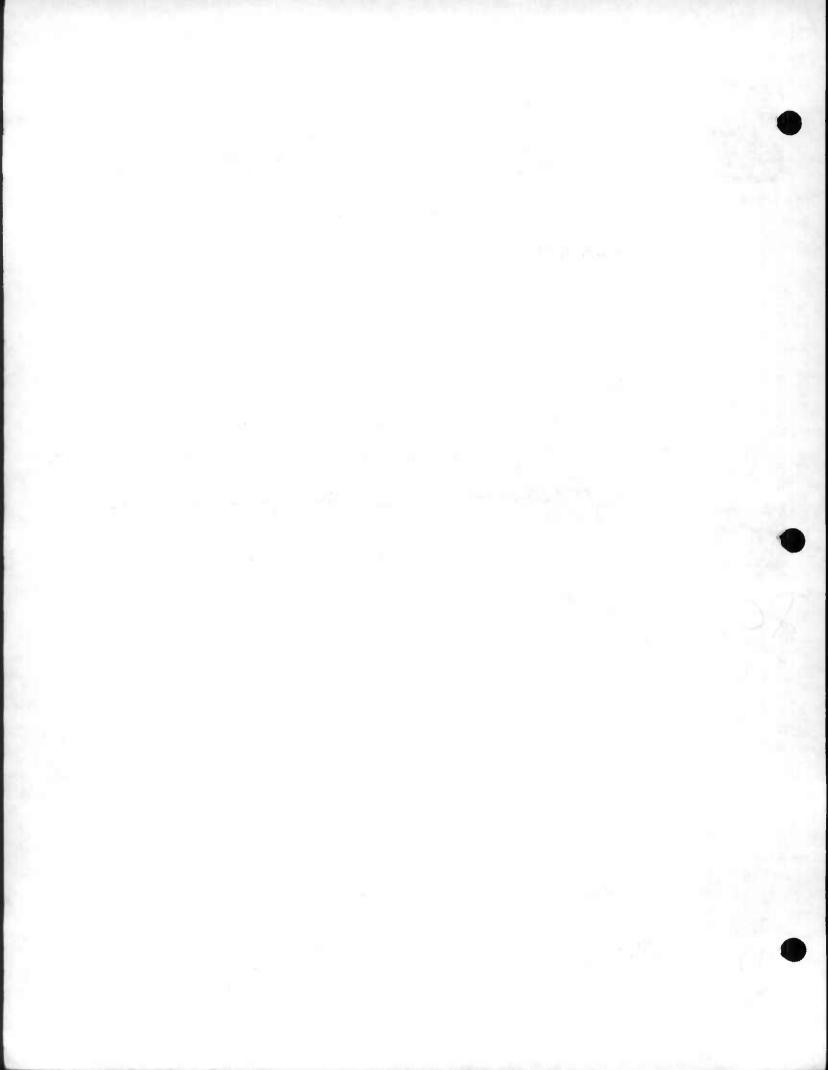
29c. License number 29d. Date signed (Month, Dey, Year) N9951

April 13, 1998

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

600 N. Wolfe St. Pathology 509. Baltimore Maryland

21287



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Kiser 1958 22:00 20 April /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, giva street end number Examiner Baltimore Bultimore City Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) If Undar 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 F Months Deys Yrs. Director 256-24-5707 Usuel Residence of Decedent with the Maryland r 28a-f show 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director N/A Baltimore 10e. Sfreet end Number 10f. Zip Coda 10g. Citizen of Wher Country? in and Mental Hygiene. 7 is marked other than "naturs!", or items 23s or transitic event, the Medical Examiner Distriction permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a and injury or other traumatic event, the Men 21207 3607 Monawk Ave. USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 0 / 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status Types 2□No 1941/ If Yes, Give Year or Dates: 1945 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Truck Driver Industrial 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middla, Last) Samuel O'Bryant Rose Miles 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Clty or Town, Stete, Zip Code) W.E. Howell, Sr. (Nephew) 3813 Milford Ave., Baltimore, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cematary, crametory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Spacify) rid. VA Cem.-Garrison 04/27/98 Owings Mills, MD 21. Signature of Funerel Sarvice Licensae 22. Nama and Address of Facility Unity Funeral Home - 108 3. North Ave. 21201 - (410) 752-4941 Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errast, shock, or heart failure. List only one ceuse on each line. Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) Qweeks neumonia Examiner Due to (or es e consequence of): Physician/Medical Examiner 1050151S Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting In death) Last Due to (of es e consequence of): Due to (or es e consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure, Non-Insulin Departent by Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to Drabates Meilytos, Chronic Manul Farluse completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical etely filled in by the funeral director, 25. Was case referred to medicat exeminer? Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et fine time, date end piece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier edicai (Check only one)

29c. License number

2556996-1031

Street, Beltimore, MD,

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signatura and title of certifier

31. Dete filed (Month, Day, Year)

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APR 22 1998

30. Neme and eddress of person who completed pluse of deeth (Item 23e) (Type, Print)

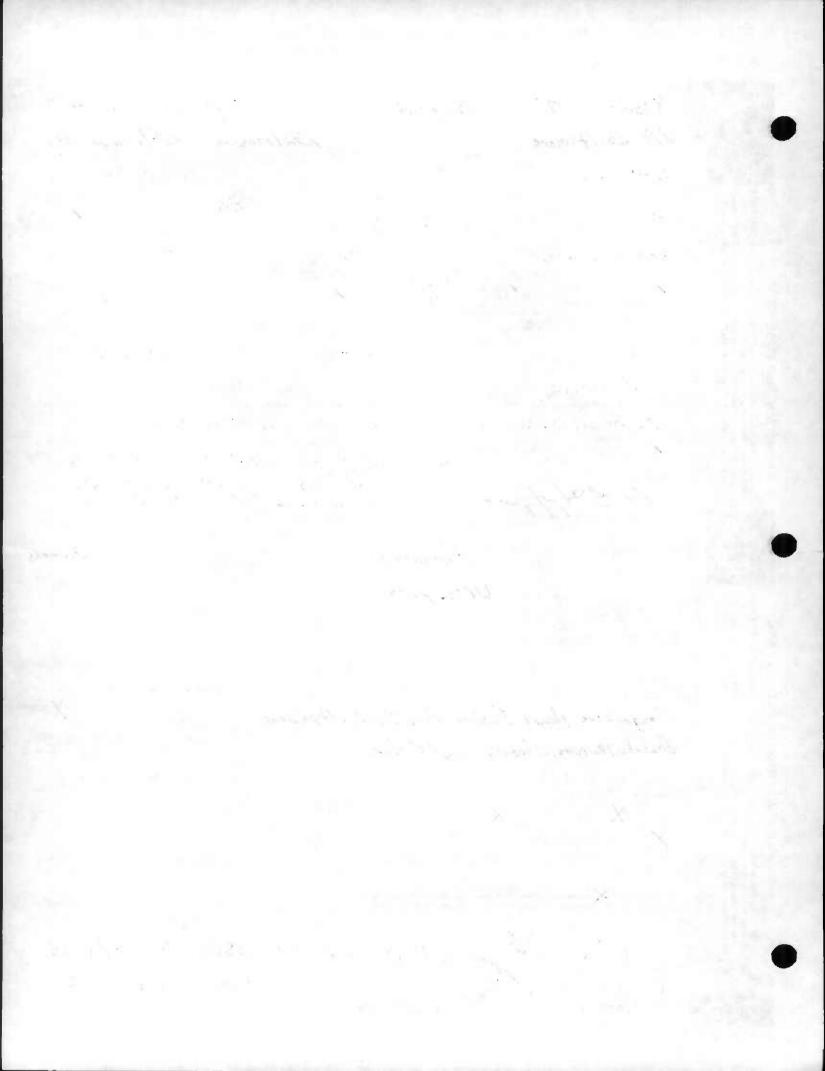
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Division of Vital Records, P.O. Box 68760,



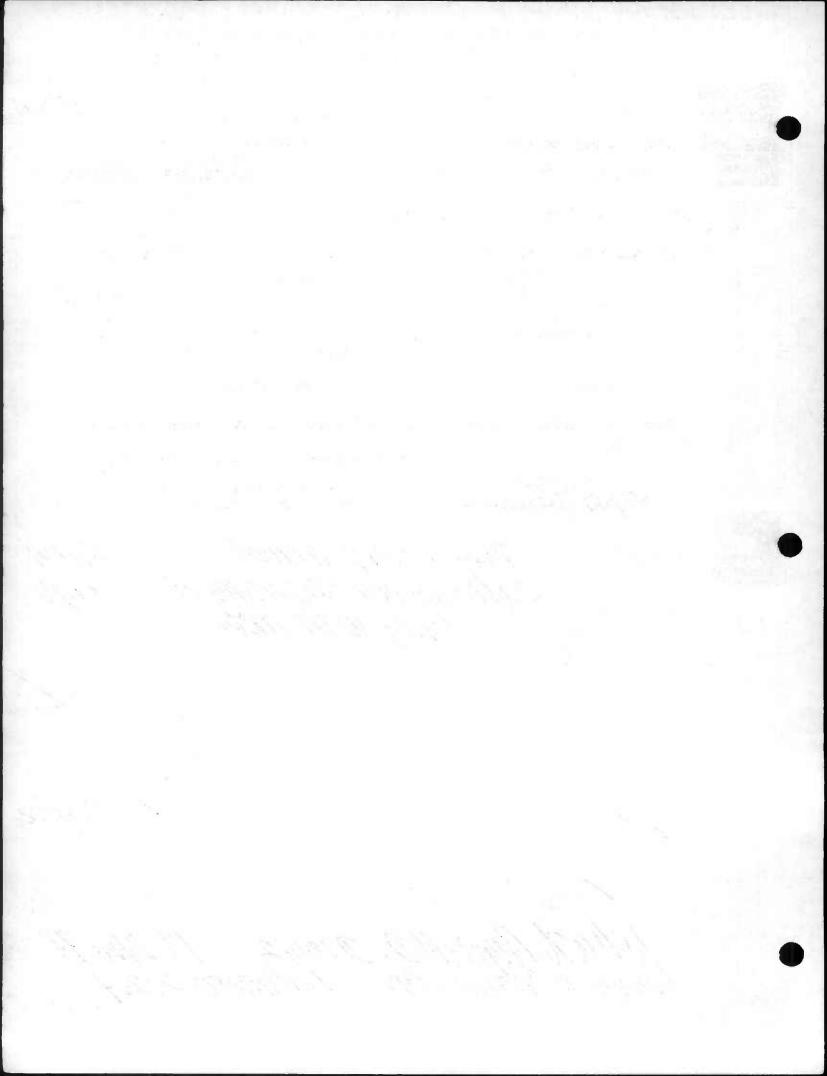
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decement's Name (First Middle Last) 2. Date of Death 3. Time of Death 800 **Physician** Month 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner **Baltimore** Joseph Richey Hospice N/A 5. Social Security Number 6. Sex 1 M 2 F if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 58 Yrs Director 219-26-5303 Dec. 18, 1939 Maryland Usual Residence of Decedan the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at MD Baltimore Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3701 North Point Rd. #63 21222 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. filed within 72 hours ofter 1 □ Navar Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada complated) pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiane. Important: If fem 27 is marked other than any Injury or other traumatic avant Elemantary/Secondary (0-12) College (1-4or 5+) Stock Clerk Retail Store 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be Semour Pigott Leila Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Barbara Johnson/Step Sister 3701 North Point Road, Baltimore, MD 21222 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4-21-98 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service CAFA- Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 tunar 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Causa (Disaasa or Injury that initiated events resulting In death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical physica 88 Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? by the 1 TYee 2 No 3 Probably 4 Unknown by 8 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s certificate 1 Tyes 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was case refarred to medical examinar? Be 26. Placa of Daath (Check only ona) Other: 4□ Nursing Homa 5□ Residence ဥ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other SHIS er of Death 28d. Dascribe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Panding Investigation 1 Natural within 24 hours effer death.

To the Funeral Director: A completely filled in by the ft death. 1 Yes 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the tima, data and placa, and due to tha cause(s) and manner as stated.

Medical Examinar: On tha basis of examination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) 29a. Certifier Medical (Check only To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year

State Registrar 30. Na

31. Date filed



State of Maryland / Department of Health and Mental Hygiene 🔾

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month WARREN RICE 9:10 Pm APRIL /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner CHURCH MARYLAND HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 2191828 Yrs Director MARYLAND Usual Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f sho traumatic event, the Medical Examiner must be notified a XXYes 2 No Be Completed by Funeral Director MD CITY BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 SOUTH BROADWAY 21231 U.S.A. 12. Was Decadent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: WHITC 15. Decedent's Education (Specify only highest grede completed) 16a. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM H. RICE, SR. FLORENCE V. VOLLERDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) i if Itam 27 i WILLIAM RICE, JR./ BROTHER 344 ELRINO STREET BALTIMORE, MD 21224 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CEMETERY 4/20 BALTIMORE, MD 22. Name end Address of Facility CHARLES S. ZEILER & SON, INC. art . Enter the disease, or complications that caused the hock, or heart failure. List only one causa on aach lina. 6224 EASTERN AVENUE BALTIMORE, Approximata Approximata Interval Batween Interval Batween Onset and Deeth **Physician** Immediate Cause (Final diseasa or condition resulting In death) /Medical CARCINOMA OF TONGUE WITH OBSTRUCTION TO PHARYMX Examiner Physician/Medical Examiner SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last DESTRUCTIVE PULMONARY DISEASE CHRONIC Due to (or as a consequence of) SEVERE ANEMIA Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of deeth? 1 Yes 2 No 3 Probably 4 Punknown þ 24b. Wera autopsy findings eveilable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 2 PNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) RECOVERY CARE 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Tes 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) complataly fillad in by 4 Homicida 1 Certifying Phyelclan: To the best of my knowledga, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifiar (Check only one) To the Within 2 To the 29b. Signature and titla of cartifier 29d. Date signed (Month, Day, Year) 29c. License number APRIL-1718, 1998 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) BALTIMORE 31. Date filed (Month, Day, Year)
APR 22 State Registrar

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Baltimore, Maryland 21215-0020

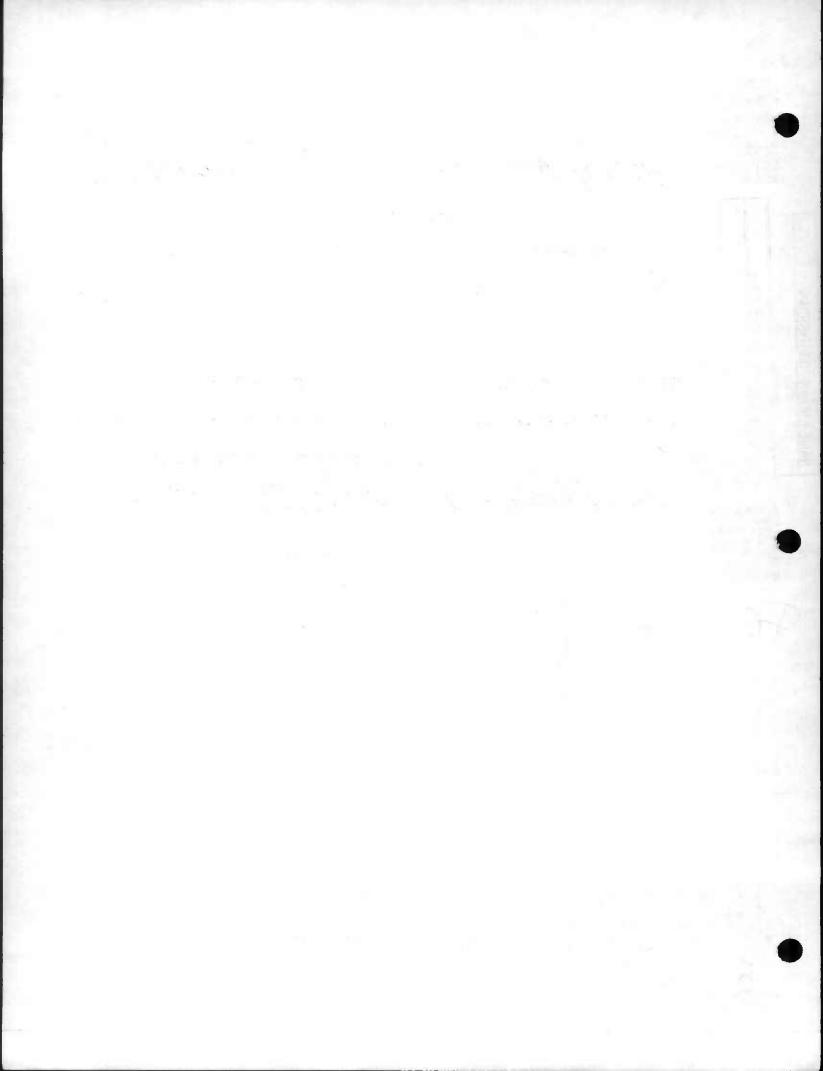
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Records,

Division of Vital or Attanding Physician:

Hospital

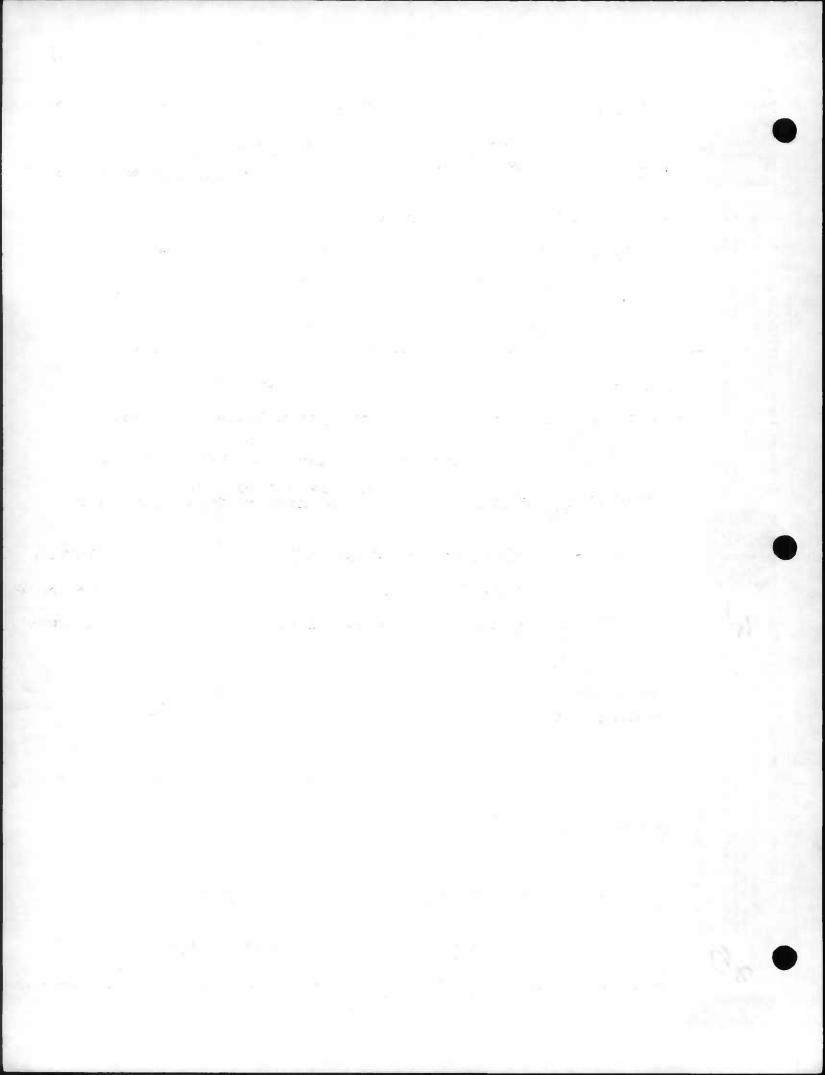
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4			JOHNS HOPKINS						3KUTIA						
	Funeral Director			Sex 7. A 1 ☐ M 2 💢 F	ge (In yrs. 42	last birthday Yrs.	Month	er 1 Year B Days	If Undar 24 Hours	Min. (Month, D	nth ay, Year)	9. Birthp Coun	lace (State or Foreig try) .ngton, DC		
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	show	10a. Slate 10b. County 10c. City, Town or Location										10d. Inside C			
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1213-0020	nath Colore	ete	15. Decedent's l (Specify only highast g	Educetion rada completed)		16a. Dece	e kind of v	vork done	ation during most of d)	f working	16b. Kind of	6b. Kind of Business/Industry			
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yland	id be ental ked o	To B	Lon Kerby						Dolo	res Krah					
Mary	end end ls m	-	19a. Informant's Name/Relationship Richard D. Reinde												
e,	Health Health John 27	-	20a. Method of Disposition		20b. F	Place of Disp	osition (A	ame of		Apr ^{Date}	20c. Location	n - City or To	wn, State		
Saitimor	Peges nent of nt: If It		1 Burlal 2 Cramation 3		Э	+ /Mac	_			27, 1998	Laure	el, MD			
	교본론증	-	4 Donation 5 Other (Specify) Balt./Wash. Crematory 27, 1998 Laure1, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
Ď	Depermination De	ļ	Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045												
		-	23a. Part1. Enter the disease, shock, or heart failure. List onl	polications that ceus	ad Iha deal	h. Do nol er	5555 ntar lhe m	Twin	Knolls	rdiac or respiratory	umbia,	MD 21	045 Approximate		
	Physician		shock, or heart failure. List onl	y one ceuse on each	line.							i	Intarval Between Onset and Death		
	/Medical		Immediate Cause (Final disease or condition	CATTO	141		1.	3 DAYS							
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	end	Examiner	Sequentially list conditions,	b	Due to (or as a consequence of):										
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5	offing th.: Afte e fun	atio	1 Natural 5 Pending 2 Accident investigati		(Month, Day Year) Injury Work?										
DIVISION	the Hospital or Attending I hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Certification:	3 Sulcida 6 Could not determine	d 286. Place of I	njury - At h etc. (Specia		treet, fact	ory, office		28f. Location City or To	18f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	the the the major	Ned	one)	and manner s	stated.			On Lineau	a number		29d Date sin	ned (Month	Day Veer!		

APRIL 16 199 600 N. WOLFE ST RES-000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) TOWER 110 JOHNS HOPKING HOSPITAL BALTIMORE, MARYLAND OLIVER BALON, MD State Registrar

1998



To the within 2 To the complex

State Registrar

31. Dete filed (Month, Day, Year)

30. Nama and addrass of person who completed (of daath (Itam 23a) (Type, Print)

29b. Signature and title of certifier

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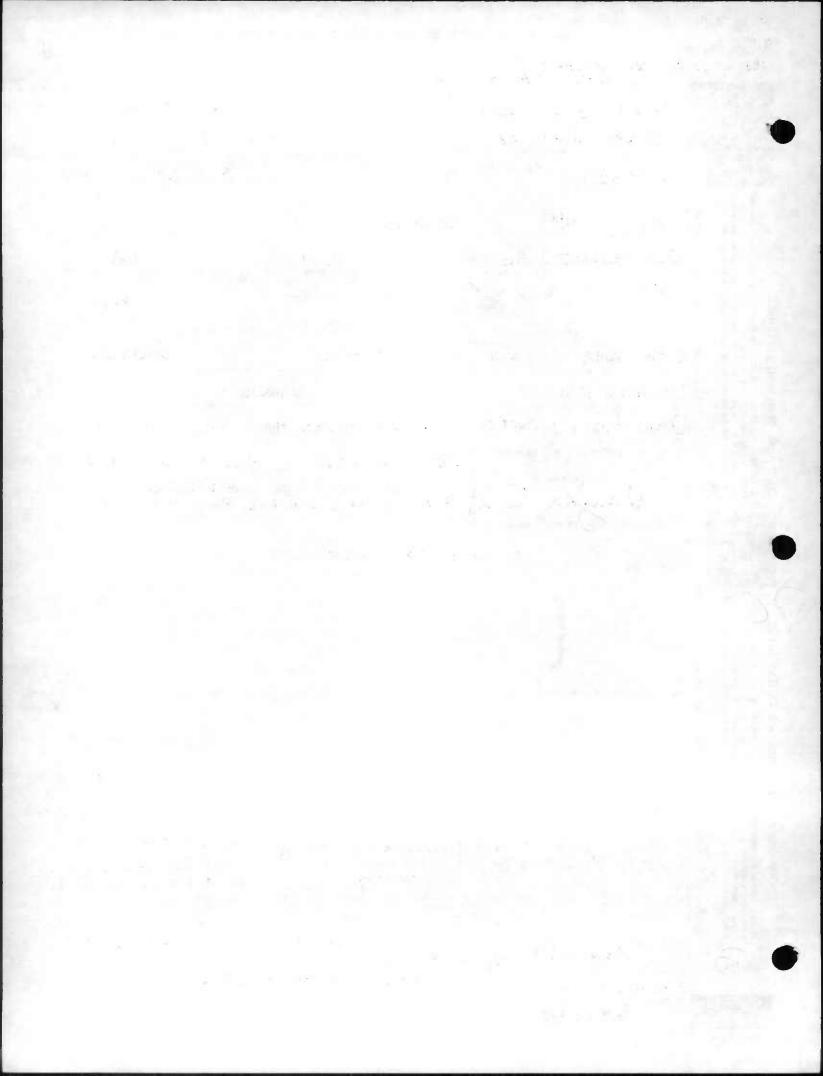
29c. Licanse number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Dete signed (Month, Day, Year)

APRIL 13, 1998



Months

Yrs.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth April F. 21, 1998 Elizabeth Stevens 4:30 AM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23 Madary Rd. Severna Park Anne Arundel 8. Dete of Birth (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 1□M 2ÅF

Hours

March 22, 1911 Maryland

10d. Inside City Limits

Approximete Intervel Between Onset and Death

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Dev. Year)

few week

White

UNKNOWN

1 ☐ Yes 2 No

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

219-28-8381

Usuel Residence of Decedent

permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or flams 23a or 28a-f ahow 7 is marked other than "natural", or flams 23a or 28a-f ahow traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

Injury or any Ir **Physician** /Medical **Examiner**

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Examiner -tranburiel-Physician/Medical the phila 80 USB þ Completed has page 2 director, Be 2 funeral Certification:

29a. Certifier

(Check only one)

29b. Signature and titl

31. Dete filed (Month, Dey, Yeer) APR 22 1998

Medical

State

Registrar

signed by the e or Attanding Physician: after death. Director: After this certific Hospital 24 hours ? To the To the To the F

10a State 10b. County 10c. City, Town or Location Director Maryland Anne Arundel Severna Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23 Madary Rd. 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria Worker Schools 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) B1enk Michael Margarete To 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Helene U. Frei (Daughter) 23 Madary Rd. Severna Park Md. 21146 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4/23/98 Glen Burnie, Maryland Holy Cross Cemetery 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Facility
Stallings Funeral Home PA 21. Signature of Funeral Serven Lightsee 3111 Mountain Rd. Pasadena, Maryland 21122 or shat caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest its on each line. 23e. Pert1. Enter the diseese, or complication shock, or heert failure. List only one ce Immediate Ceuse (Finel ancreatic disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed' 1 Yes 2 PINO 25. Was case referred medical examiner? 26. Piece of Deeth (Check only one) Other: 4 □ Nursing Home 5 ☐ Nesidence 8 □ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide

s of person who completed cause of deeth (Item 23e) (Type, Print)

Mo

32. Registrer's Signature

HAMBERLAIN

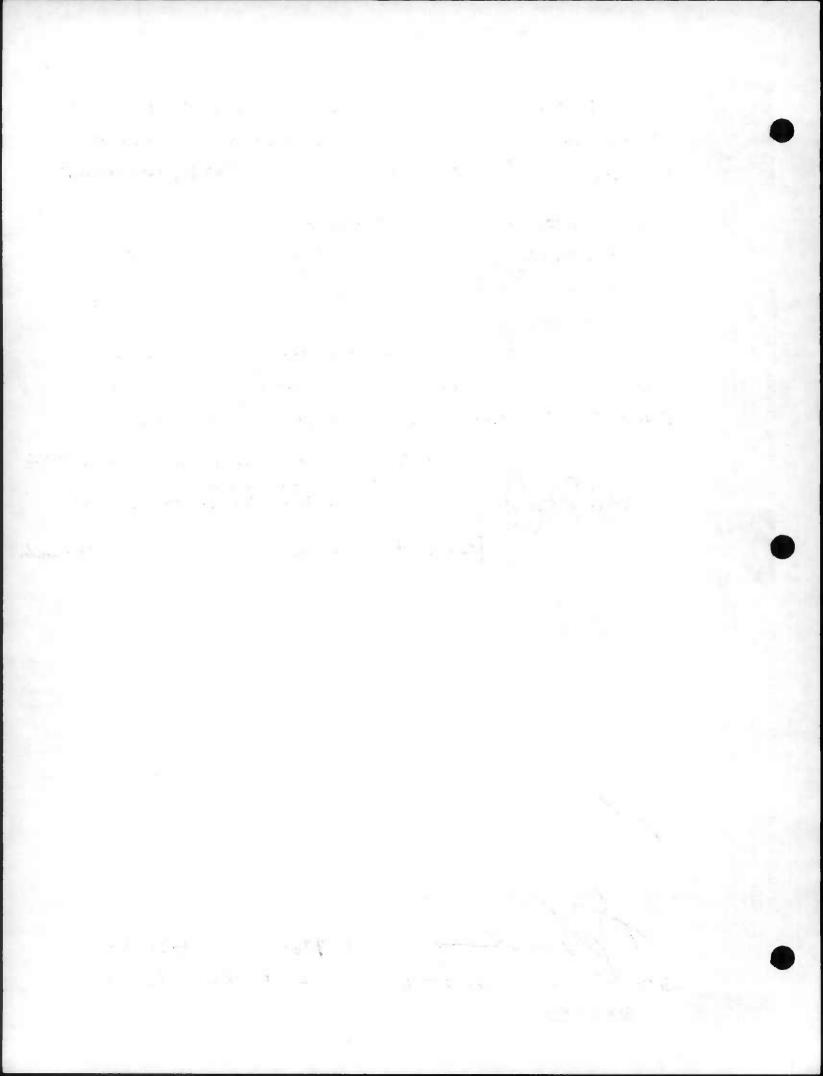
1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

- Fandall

29c. License number

w: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

277 PENINSULA FARM RO ARNOLO MO 2/012



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend: 7 Per FH Film G758 4-22-State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Simmons pril /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not institution, giva street and number) Examiner Baltimore Baltimore Cita Singi Hospitai If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, 9. Birthplaca (Stata or Foreign Country)
UICGINIA 7. Aga (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number **Funeral** Months Days 1□M 2XF 229-30-0074 70 69 Yrs. Director Usual Rasidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental Hygiena. Anti-filem 23a or 28a-f show shill filem 27 I a marked other than 'natural', or items 23a or 28a-f show uny or other traumatic event, the Medical Engineer man for retified at 10a. State 10b. County 10c. City, Town or Location 10d. inslda City Limits BALTIMORE 1 Yas 2 No MO Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 28 DOWLING 48 Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 DNo If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, etc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: DLK by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Collega (1-4or 5+) Elementary/Secondary (0-12) HOUSE KEEPER DOMESTIC 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a, Informant's Name/Ralationship (Type, Print) BILLIE SIMMONS 28 DOWLING Cir. (DAUghter) BALTIMORE, MD 21234 20b. Place of Disposition (Name of certainty, cramatory or other place) 20a. Mathod of Disposition 20c. Location ; City or Town, Stata permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Ramovei from State MY MEM. PK 4 Donation 5 Other (Specify) 22. Nama and Addrass of Fecility 21. Signature of Funaral Sarvice Licensaa E.L. PHILLIPS 1721-27 N. MONIEST. BACTIMORE, MD 21217 Heckn retha 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical 2 weeks SEDSIS Examiner Due to (or as e consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): SB esn signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TUnknown upertension, diabetes Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificata hes b director, pega 2 s 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☑Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant

funerel n 24 hours efter death.

The Funeral Director: After the pletely filled in by the funeral

To the Hosp within 24 hor To the Fune completely fi Registrar

edicai

31. Date filad (Month, Day, Year)

Heather

29b. Signatura and title of certifian

3 Suicide

29a. Cartifian

4 T Homicida

(Check only one)

6 Could not be detarmined

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) Boxerman SINGI

house officer

32. Registrar's Signatura In Davidson Handall

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

1 🗹 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the causa(s) end menner stated.

29c. Licansa number

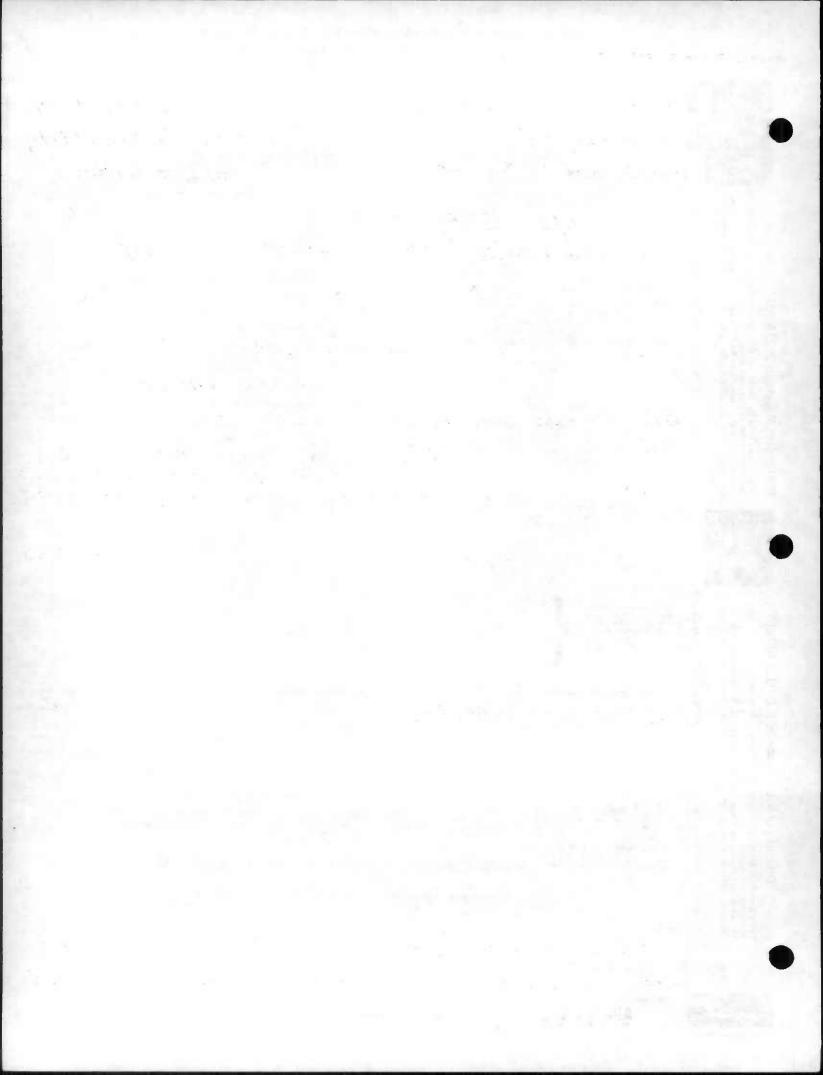
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28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

Hospital Baltimore, maryland

29d. Data signad (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** April 19, 1998 Edith O. Schwing 5:30 A.M. /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 106 S. Collins Avenue N/A Baltimore If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Yrs 124-22-3186 85 Jan. 16, 1913 New York Director Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits Show 7 is marked other than "naturel", or frems 23s or 28s-f shot treumstic event, the Modical Examiner, must be notified at 1 M Yes 2 □ No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 S. Collins Avenue 21229 United States Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mentel Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Enos O'Dell Emma Monroe 19a. tnformant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jerry A. Schwing/Husband Department of Heelth mportant: If Item 27 106 S. Collins Ave., Baltimore, MD 21229 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 Green Mount Crematory 4-21-98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
CAFA - Stephen D. Lohrmann, P.A. 21. Signature of Funeral S Dumaun 8717 Green Pastures Drive, Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Examiner certificate be executed buriel-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use es the burie Physician/Medical Due to (or as a con ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by ti should be detach 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to Completed 24e. Wes en eutopsy completion of cause of death? page 2 hes 1 ☐ Yes 2 ☐ No certificate 20 No To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifies director, Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) examiner Other: 4 Nursing Home ome 5 Residenca 6 Other (Specify)
28d. bescribe how injury occurred P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certification: 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Neturel 2 Accident 1 🗆 Yes 2 🗆 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

(6 W.

5

29d. Date signed (Month, Day, Year)

State

edicai

29a. Certifier

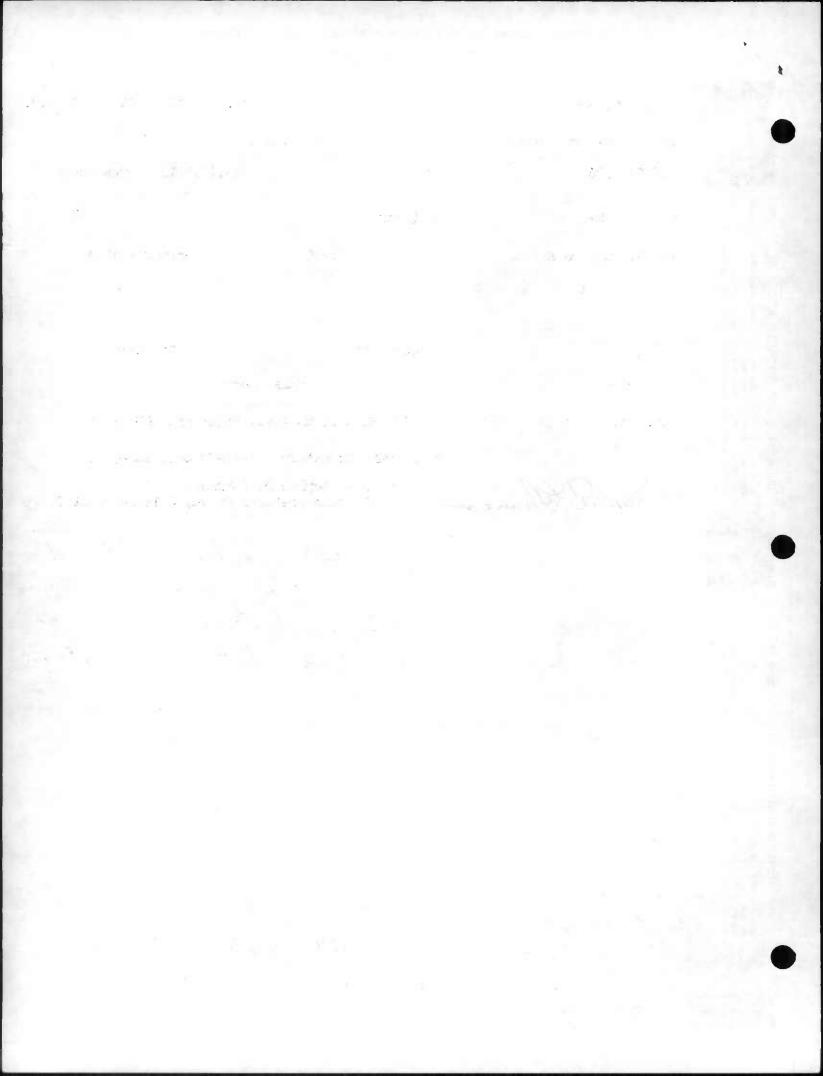
mores

29b. Signature and title of certific

Registrar

32 Registrare Signature
Juna Dundon-Randalle 31. Date filed (Month, Dey, Year) APR 2 0 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 19 1998 Joseph Olin Starck, Jr. 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE 6. Sex 1 XM 2 ☐ F 7. Age (in yrs. lest birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth Months Days Hours Min 69 November 25,1928 10b. County 10c. City, Town or Location Essex

Director the Marylenc r 28a-f show item 27 is marked other than "natural", or items 23s or other traumatic avent, the Medical Examines must be in Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. Department of Health a any Injury or **Physician**

Physician

Funeral

/Medical Examiner ician end buriel-transit physician the buriel

paga 2 certificata this funerel

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: Af

Certification:

completaly within 2. To the

State Registrar

edlcai

8:22 AM /Medical 4e Fecility Neme (If not institution, give street end number) Examiner GREATER BALTIMORE MEDICAL CENTER 5. Sociel Security Number 9. Birthplace (State or Foreign 217-22-0647 Maryland Usuel Residence of Decedent 10e. State 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 168 1/2 Riverside Road 21221 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Roofer Construction 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Joseph O. Starck, Sr. Catherine Unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 168 1/2 Riverside Road Essex, MD 21221 Mark J. Starck, Sr. / Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 4/23/98 Parkwood Cemetery Parkville, Maryland 22. Name and Address of Fecility 21. Signeture of Funeral See Leonard J. Ruck Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) yeuv Examiner Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Yes 2 No 3 Probably 4 Unknown ò 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Dete of injury (Month, Dey Year)

6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

28c. Injury et Work?

1 Yes 2 No

29b. Signeture end title of certifier

5 Pendina

investigation

27. Manner of Deeth

1 Neturel

2 Accident

29c. License number

29d. Date signed (Month, Dey, Year)

28d. Describe how Injury occurred

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

6569 N. Charles St, Baltmore, MD 21204
Registra's Signatura Robert Shepard, MD

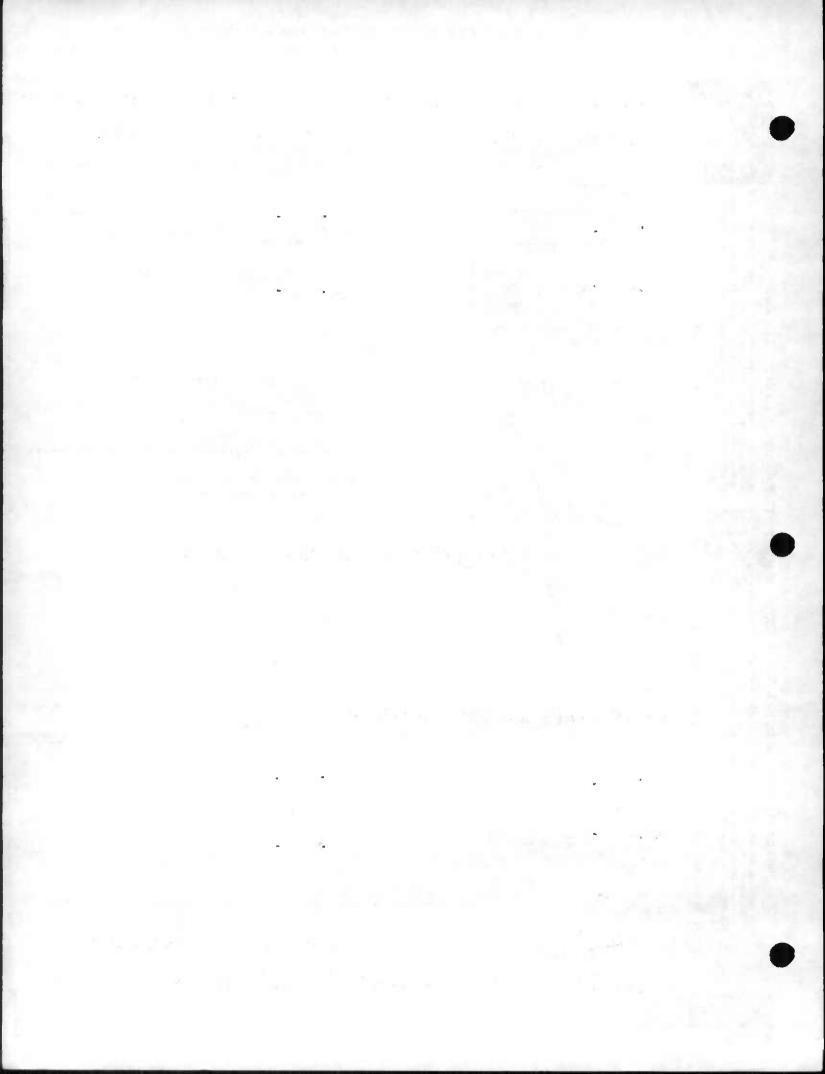
28b. Time of

APR 22 1998

32. Registrer's Signeture he Deviden , = ,

	Certificate of Death		Reg. No.								
Physician /Medical	1. Decedent's Name (First, Middle, Last) LAWRENCE J. SABATINO	2. Date of Daa APRIL	3. Time of Death 6:15 PM								
Examiner	4a Facility Nama (If not institution, giva street end number) MANOR CARE NURSING HOME 4b. City, Town, or Lo		4c. County of MONT G	f Death GOMERY							
Funeral Director	5. Social Sacurity Number 6. Sex 156 M 2 F 90 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Dey SEPT. 1	7, Year) 4,1907	9. Birthplace (State or Foraig Country) NEW JERSEY							
M W	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location		7	10d. Inside City Limits							
r 28a-f show rectified at	MD. MONTGOMERY BETHESDA			1⊠Yes 2□No							
Por 2	10e. Street and Number 10f. Zip Coda 20817	10g. Citizan of Wh UNITED									
al, or items 23s or 28s-f si Exeminer must be notified by Funeral Director	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Datas: 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never in U,S. If Yas, specify Cuban, Maxican, Puerto	ecify Yes or No- Rican, etc.)		- American Indien, , Whita, etc.							
ovent, the Medical Exposure, by Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) LAWYER	ing	g LEGAL								
To Be Com	17. Fether's Nama (First, Middle, Last) 18. Mothar's Name										
of C	DOMINIC SABATINO ANNA		IBRIZER								
traur	19e. Informant's Name/Relationship (Type, Print) BETTY C. SABATINO, WIFE 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6921 GRANBY ST., BETHESDA, MD. 20817										
reportant; if item 27 is marked other than any injury or other traumatic event, the Monce. To Be Comp	20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place)	Date 4/17/98		ORIA, VIRGINIA							
important: If ite any injury or of once.	21. Signature of Funeral Service Licensee 22. Name and Address of Eacility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882										
g physicien end lungs the buniel-transit aurille edical Examiner	Ceuse (Disaase or Injury that initiated evants resulting in death) Last C	rail	ure								
deteched for use expeding	d	23b. Did to	obacco use cont	ributa to the cause of death							
be deteched by III	cerebrovascular disease	101	1 Yas 2 No 3 Probably 4 Unkno								
should should			Was an autopsy performed? 24b. Were eutopsy available prior tomplation of death?								
page 2		1 🗆 Y	1 Yes 2 No 1 Yes 2 No								
rector rector	25. Was case refarred to medical axaminar?			(0							
五百		toma 5 ☐ Residence 6 ☐ Othar (Specify) 28d. Describa how Injury occurred 28f. Location (Street end Number or Rurel Route Number,									
To the Funeral Director: After completely filled in by the funeral Medical Certification	4 Homicide determined building, etc. (Specify) 29a. Certifiar Cartifying Physician: To the best of my knowledga, deeth occurred et the time, date and place,	City or Tow	vn, Stete)								
he Fur pletely edica	(Check only one) 2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occur and menner stated.	red et the tima, o	date and plece, e	nd due to the cause(s)							
Toth	29b. Signatura and title of confiler 29c. Licensa number		112	(Month, Day, Yaar)							
	0 36791		APRIL 17	,1998							
	30. Name and address of person who complated causa of deeth (Item 23a) (Type, Print) A Such as 10 ZUS Femure 12d, Barling 31. Date filed (Manufi, Day, Year) 32. Registrar's Signeture	sos	MS	20817							
State Registrar	APR 2 2 1998 A Section 2000 00										

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth April 19,1998 **Physician** 4:00PM M. Stacharowski Theresa /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner Ivy Hall Nursing Home Baltimore Essex 5. Social Security Number 215-30-1491 If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys 1 ■ M 2 TF 69 Yrs **Director** MD Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or frems 23s or 28s-f show any injury or other traumatic event. In Medical 10e. Stete 10b. County 10c. City, Town or Location 10d. fnalde City Limits MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5904 Hamilton Ave. 21237 USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 TNo If Yes, Give X Year or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Educetion (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 0 Food Server Essex Comm. Col 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Diegel Theresa (unk.) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5904 Hamilton Ave. Baltimore, MD Eugene Stacharowski/husband 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 17 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4-23-98 Dulaney Valley Mem. Timonium, MD 21. Signeture of Funeral Service Lice 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 1211 Chesaco Ave, Rosedale, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) + Philaday Physician/Medical Examiner 1 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760, Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Pert It. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed page 2 s certificate hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No vurs efter death.

•ral Director: After this certificatilled in by the funeral director. To the Hospital or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 29e. Certifier edical completely 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted. (Check only 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 14221 4.20 84 30. Name and address of person who completed cause of death (Itapy 23e) (Type, Print) 221 BALL - and 2/22/ 31. Dete filed (Month, Day, Year) 32. State Registrar

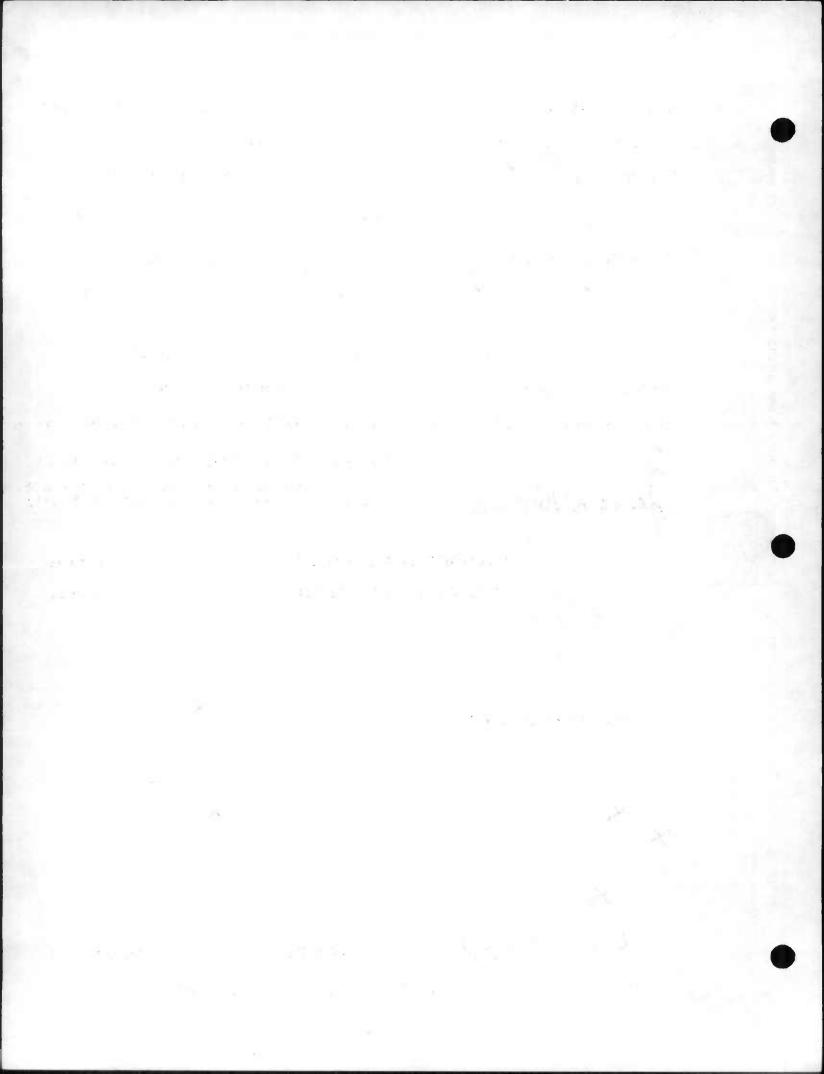
DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** 20, 1998 9:40 A TAYLOR, ANN M. April /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 2309 N. Pulaski St. Baltimore
If Under 24 Hrs.
Hours Min.
Bec. 5, 1 Baltimore N/A If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 10 M 20 F Months Days Yrs. 73 **Director** 215-22-5009 Usuel Residence of Decedent 1924 the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits r 28a-f show 12 Yes 2 □ No Director MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with r than "naturel", or items 23s or the Medical Examiner must be 2309 N. Pulaski St. 21217 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th i. Pages 1 and 2 should be filed witness of Health end Mental Hygien tant: If item 27 is marked other the lury or other treumatic event, the Private Duty Nurse Health 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph M. Jessup Katherine Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Max Taylor, Sr. (Husband) 2309 N. Pulaski St., Baltimore, MD 21217 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any Injury or o 1 Buriel 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) VA Cem.-Garrison 04/24/98 Owings Mills, MD 21. 2 gn ture of Funerel Service Licensee 22. Name and Address of Facility Unity Funeral Home - 108 W. North Ave. Baltimore, MD 21201 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,
one cause on each line. Baltimore, MD 21201 - (410) 752-4941 Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical CARDIOPULMONARY ARREST Examiner 6 mins. Due to (or as a consequence of): Physician/Medical Examiner METASTATIC LUNG CANCER 3 mos. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequença of) that initiated events resulting in death) Last Due to (or es e consequenca of): 980 23b. Did tobacco use contributa to the causa of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown COPD, HYPERTENSION à 24b. Were autopsy tindings aveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed page 2 s certificate has 1 Yes 1 Yes 2 No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 1 SNatural 2 Accident 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? Hospital or Attending 5 Pending investigation s after death. 1 Tes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D43173 4/20/98 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) Lawrence Scharf, M.D. 7605 Osler Drive Towson, MD 21204 31. Date filed (Month, Day, Year) State

Registrar



		Plea		Print in Black in					-		
CALLIE THORNTON			State	of Maryland / Dep <i>Ce</i>	artment of rtificate o				iene g	8 1	2676
Physician /Medical	LAI		ie, Last) THORI	NTON			4	2. Date of Dear Month APRIL	Day 17, 19	Yaar 998	3. Time of Death 2:40P.M.
Examiner	4 40 1010 81 41			umber)		4b. City, To BALT		ocalion of Death	4c. Cour		
Funeral Director	5. Social Security N 238-28-43		6. Sex 1 □ M 2 💢 F	7. Age (In yrs. last birthday, 73 Yrs.	Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day MAY 4,	Year) 1924	9. Birth Cou	place (State or Foreign into) TH CAROLINA
73	Usual Residence of Decedent										
the Marylenc 28=1 show notified at	10a. Slala MARYLAND	10b. County	′	10c. City, Town or L BALTII							10d. inside City Limits 1 ☐ Yas 2 ☐ No
th with the	10e. Streel and Nur		ON AVE. A	PT 212	10f. Zip Code 21217			1	og. Citizen o	f What Cou	intry?

Funeral 11. Marital Status þ Completed

Peges 1 and 2 should be filed within 72 hours effer deeth w rent of Health and Mentel Hygiene. nt: If tem 27 is marked other than "natural", or items 23a. ? is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Be permit. Peges Depertment of Important: If it any injury or o

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examine

Physiclan/Medical

þ

Completed

Certification:

Medical

and I-transit lew requires thet the death certificate be executed physician ar Division of Vital Records, P.O. Box 68760, as USB signed by tha e certificate has b lirector, paga 2 s The Physician: Be To this luneral

DORIS M. FORSYTHE DAUGHTER 20a, Method of Disposition 1 DeBurial 2 Cramation 3 Removal from Stala 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensae 21. Signatura of Funeral Service Licensae

LLOYD M. ESTEP

BROTHERS FUNERAL HOME,

1300 EUTAW PLACE, BALTIMORE,

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

POWELL

701 N. ARLINGTON AVE, APT 212

15. Decedent's Education (Specify only highest grada completed)

1 □ Navar Married 2 □ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

DENNIS

17. Fether's Name (First, Middle, Last)

19a. Intormant's Name/Relationship (Type, Print)

12. Was Decedani Evar in U,S. Armed Forces?

1 ☐ Yes 2 No

College (1-4or 5+)

20b. Pleca of Disposition (Name of cemetery, cremetory or other place)

BALTIMORE CEMETERY

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 Yes 2 No Specify:

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired)

HOMEMAKER (PRIVATE NURSE)

600 A CHERRYCREST ROAD, BALTIMORE, MARYLAND 21225 Data 20c. Location - City or Town, State

18. Mother's Name (First, Middle, Maiden Surname)

BELUAH

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

POWELL

14 Bace - American Indian

Specify: AFRO. AMERICAN

Approximate Interval Between Onset and Death

Black, White, etc.

HOME NURSE

16b. Kind of Business/Industry

4/24/98 BALTIMORE, MARYLAND ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND

Immediate Cause (Final disaasa or condition resulting In death) Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Cause (Disease or Injury that Initioted events resulting in death) Last

Due to (or es a consequence of) Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical axaminer? 1 Yes 2 No

2 Accident

3 ☐ Suicide

4 Homicide

27. Menner of Death 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year)

28b. Time of

Other: 4 ☐ Nursing Homa 5 【 Residence 6 ☐ Other (Specify) 28c. Injury et Work?

1 Yes 2 No Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

24a. Was an autopsy performed?

26. Place of Death (Check only one)

1 Yes 2 No

28d. Describe how Injury occurred

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

29c. License number O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29d. Dale signed (Month, Day, Year)

APRIL 18,1998

23b. Did tobacco use contribute to the ceuse of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yas 2 ☐ No

DUC

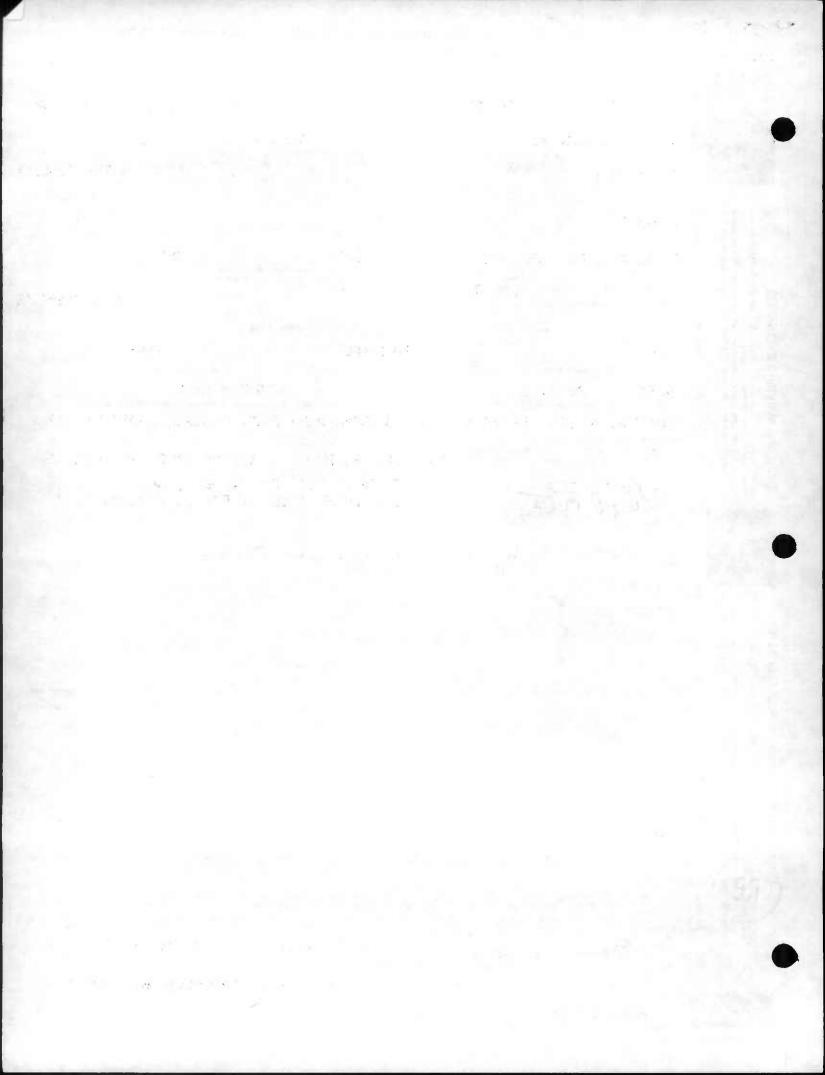
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

nun Chute no

Vennis hute up 31. Dete filed (Month, Day, Year) APR 2 2 1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Begistrar's Signature Flater Devideor Mandallis



State of Maryland / Department of Health and Mental Hygiene

LCI.	ICLLE VE	300	Items: 23 part I,II,27	per MEO G-758 4,	128/9 Certificate	of Death		Reg. No.	12	6/1			
	Physic /Medi		1. Decedent's Name (First, Middla, Las)	ighn		2. Dete of Det Month APRIL	16, 199	Yeer	3. Time of Death 1947 PM			
	Exami		4e Fecility Neme (If not institution, give JOHNS HOPKINS - E	street and number)	0	4b. City, Town, or BALTIMOI	Location of Death	4c. County	of Deeth	-7-21			
	Funeral Director		Sociel Security Number 6. Se		last birthday) If Under 1 Ye	ear If Under 24 Hrs lys Hours Min		y, Year)	~	ce (Stata or Foreign			
	Maryland f show	or	10a. Stete 10b. County	10c. Ci	ty, Town or Location				10d	I. fnside City Limits 124 Yes 2 No			
	or 28a-	Director	10e. Street and Number		10f. Zip Coo	le le		10g. Citizen of W	hat Country	n			
	be filed within 72 hours efter death with the Maryland tel thygiene. Id other than "natural", or itema 23a or 28a-f show event, the Medical Examines must be notified at	Funeral	11. Marital Stetus	12. Was Decedent Ever in L Armed Forces?	J,S. 13. Was Decedent ff Yes, specify (of Hispanic Origin? (Suban, Mexicen, Puer	Specify Yes or No- rto Rican, etc.)	14. Race Bleck	- American				
0050	ours efte	by	Never Merried 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1□ Yes 2			Specify:	Bla	ck			
21215-0020	within 72 h ene. than "natu	Completed	15. Decedent's Edi (Specify only highast grad Elementery/Secondary (0-12)	cation la complatad) College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT usa ra	cupation on a during most of wo tired)	orking	16b. Kind of Bu	siness/Indus	atry			
	filed with Hygiene. other than		17. Father's Name (First, Middla, Last)		Never	Works	me (First, Middla,	Maiden Sumama	IA_				
Maryland		To Be	Larry Vai	aghn	_	Ello	Ella Calaman						
	Health mm 27 i		19a. Informant's Name/Relationship (7)	Partlow	19b. Mailing Address (St.	net te l	Rural Routa Number Bod, Bo	Things 20c. Location -	e M	rylanderso			
Baltimore,	500		1 Burial 2 Cremation 3 4 Donation 5 Other (Spacify,	Removal from State	ta Zion C	emetery	4-23-98	Lansdo	nune	Marylon			
Ball	permit. Peg Department Important: h any Injury o pnce.		21. Signature of Funerel Service Licens	Q Q A	Joseph	H. Brown	Jr. Fu	neral H	رماده	PA.			
			23a. Part1. Enter the disease, or comp shock, or heart fellure. List only of	lications that ceused the pea ne cause on eech line	th. Do not enter the mode of		ac or respiratory ar	rest,	1 11	Apploximate Interval Between Onset and Death			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	CIRRHOSIS OF	THE LIVER				1				
-	- F	ner		Due to (or as a consequence of):								
700	ificate be elecuted g physician and as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Due to (or as a consequence of):									
68760	ng physician as the buris	Medical	that initiated events resulting in death) Last	CDue to (d	or as a consequence of):		315						
Box	deeth cart	Physician/M	Part II. Other significant conditions co	d	nulting in the underlying course	a civen in Part I	29h Did	lobacco use con	tribute to the	he causs of death?			
P.0	res that the de signed by the a	by Phys	CHRONIC NARCOTISM	This built g to doubt but not to.	suning in the underlying coust	gwon ar t art i.		Yss 2□No		bly 4 ☐ Unknown			
Vital Records,	been should	Completed b						en eutopsy med?	evelle	e eutopsy findings eble prior to pletion of ceuse seth?			
al Re					1 129-∀es 2 □ No 1 □								
r Vitt	Physician: The this certificate ral director, pag	o Be	25. Was cese referred to medica1 examiner? 1 ☼ Xes 2 ☐ No	Hospital: 1 ☐ Inpatient 2X	XER/Outpatient 3□ DOA	Other	eath (Chack only of Home 5 Resk		r (Specify)				
on of		ion: T	27. Manner of Deeth 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)		Injury et Work? 1 Yes 2 No	28d. Describe	now injury occurr	ed				
Division	C 48 6	Certification:	2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Space	ome, farm, street, factory, of	28f. Location (3 City or Tox	Straat and Number vn, Stata)	er or Rural F	Route Number,				
_	To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by th	edical C			owledge, deeth occurred et thation end/or investigation, in r								
	within To the comple	Me	29b. Signature and title of certifier	O. Chude as		cense number		29d. Date signed APRIL 1'					
	1		30. Name and address of person who co	completed cause of death (Ite	m 23a) (Type, Print) 111 Penn Str	eet, Balti	imore, Ma	aryland :	21201				

State

X X

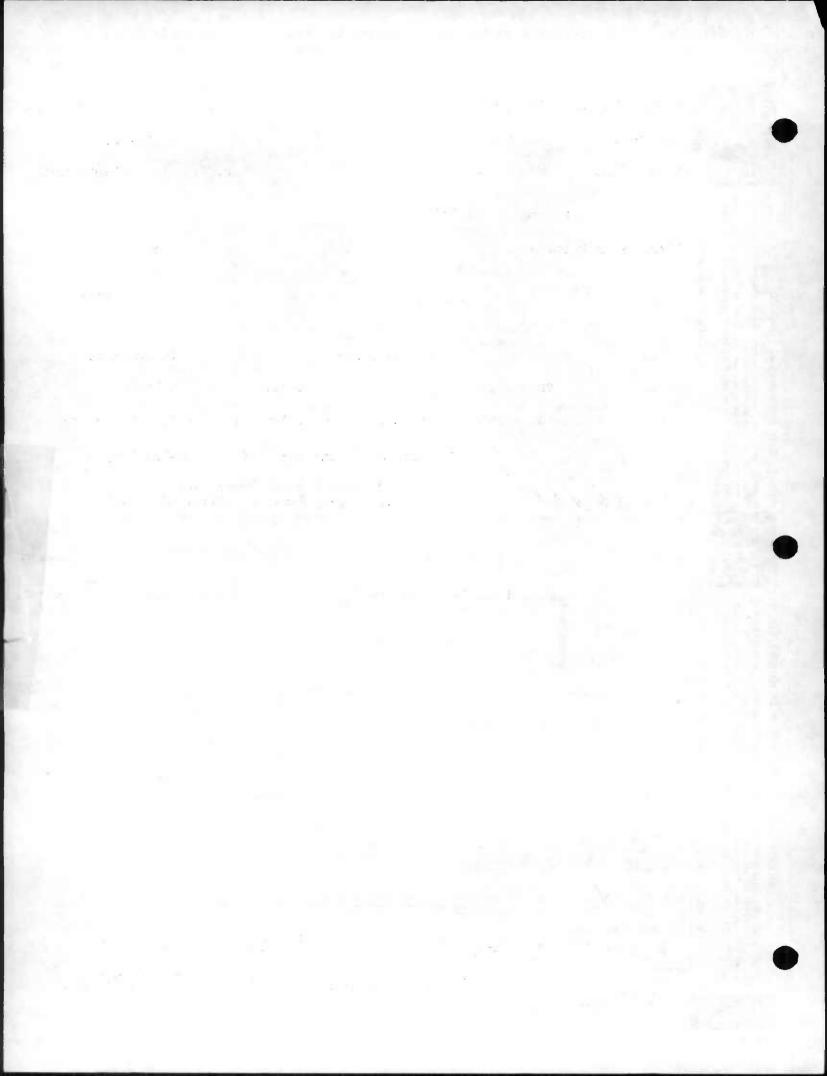
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Data of Death April 15, 1998 **Physician** Edward Kenneth Valentine 3:30 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Baptist Home of Maryland Owings Mills Baltimore If Undar 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) Jan. 28, 1915 9. Birthplaca (Stata or Foraign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1₩ 2□F Months Days Hours 579-38-5365 83 Yrs. Washington, DC Director Usual Rasidence of Decedant with the Merylend 10a Stata 10b Counts 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryle Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f ahow with injury or other traumatic event, the Medical Examinet must be notified a page. Owings Mills MD Baltimore 1 □ Yas 2 □ No Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 10729 Parks Hgts. Ave. 21117 USA Funerai 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ⊠ Yas 2 □ No
If Yas, Giva
Yaar or Datas: 1943–46 1 Navar Marriad 287 Married Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fiscal Clerk US Government 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Edward Valentine Birdie Schneck 0 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) S. Valentine - Wife Franc 10729 Parks Hgts. Ave. Owings Mills, MD 20b. Piaca of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Congressional Cemetery 4/18 Washington, DC 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Saryide Licenses 22 Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairfre. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Examiner Due to (or as a consaquance of): Physician/Medical Examiner ichan and burial-transit C The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initieted evants rasulting in daath) Last Due to (or as a consequanca of) Division of Vital Records, P.O. Box 68760, physic the t Dua to (or as a consequanca of): 80 950 signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara eutopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? hes page 1 Yas 2 No 1 ☐ Yas 2 ☑ No certificate Hospital or Attending Physician: 25. Wes casa rafarred to medical examinar? Be 26. Placa of Daath (Chack only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month/Dey Year) 28d. Dascribe how Injury occurred 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? Certification: After 1 Natural 5 Panding NA 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A Invastigation 2 Accidant 6 Could not ba 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) filled in by 4 Homicida to Certifying Phyalcian: To tha best of my knowledge, death occurred at tha tima, date and place, and dua to tha causa(s) and menner as stated. 29a. Certifier edicai completely 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only within 2 To the 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of cartifiar 6 30. Nama and address of person who complated causa of daath (Itam 23e) (Type, Print) Towson MD 32. Ragistra Silva Davidson Randall State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH WILLIAMS 3:05 AM 1998 APRIL 17 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE BALTIMORE HARBOR HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 212-34-9801 Yrs. APRIL 18.1937 MARYLAND Director Usual Residence of Decedent the Marylend r 28a-f show 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CITY 1 Yes 2 No NA Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with "naturel", or items 23a or 207R 21885 U.S.A EDAR HILL LANE Funeral deeth 12. Was Decadent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give 8 - 2 - 40 ↑ ≥ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: PYACK þ 3 ☐ Widowed 4 ☐ Divorcad 9-16-62 Pages 1 end 2 should be filed within 72 ho nent of Health end Mental Hygiene. ant: If item 27 is marked other than "naturiury or other traumatic event, the Houldel. Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MAINTENANCE ADMINISTRATOR DOMINO SUGAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERNICE LYLES WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 207 R CEDAR HILL LANE, BALTIMORE, MARYLAND 21235 LOISL)ILLIAMS (WIFE) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 4-20-90 BALTIMORE, MARKEANS 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Depertment of important: If eny injury o METRO CREMATORY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licansee JOSEAN H. BROWN JR. FUNERAL HOME, PA 2140 N. FULTONAVE, BALTIMORE, MARYLAND 21017 23a Part 1. Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final METASTATIC CARCINOMA OF THE LUNG MON THS disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medicai Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): physicien s the buriel O. Box 68760 thet the deeth certificate Due to (or as a consequence of): 888 USB I signed by the a d be detached f Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. þ law requires MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Wes en eutopsy Completed certificete hes b lirector, pege 2 s 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending in 24 hours after the Funeral Director: After the Funeral Director: After the Funeral Filled in by the funeral funeral f 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as stated. 29a. Certifier Medical To the Fune complately f (Check only one) 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESIDENT AS 2441614 - 39 APRIL 17 INTERNAL MEDICINE 199.8 3001 SOUTH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER STREET 0 BALTIMORE HARBOR HOSPITAL CENTER MIN THU

State Registrar 31. Date filed (Month, Day, Year)

32. Registrary Signature

MD

21225

NORMAN

WILLIAMS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If frem Z7 Is marked other than "natural", or frems 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar mass in maniferent

Physician /Medical Examiner

Vision of Vital Records, P.O. Box 68760,

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State Registrar

29a. Cartifier

Stroben S.
31. Data filed (Month, Day, Yaar)
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DHMH 16 Rev 6/95

32. Regis

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

Mandell.

MP

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

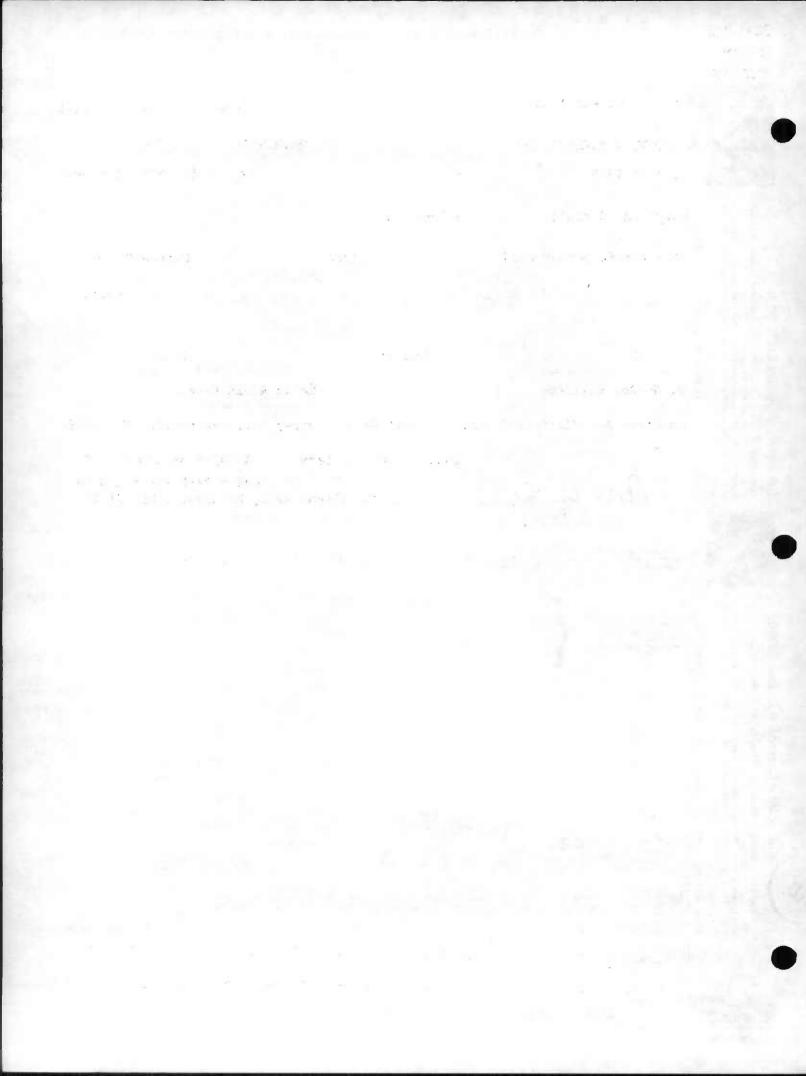
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Deta signed (Month, Day, Year)

APRIL 21,1998



Jilliams, Marrie 4/20198 5:15 Am.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** C. Williams Marie 20, April 1998 5:15 a.m. /Medical 4a. Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Manor Care Health - Rossville Rossville Baltimore Co. If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 9. Birthplece (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year **Funeral** Days Months 1 □ M 2 🕱 F 212-36-7955 Director 90 August 29, 1907 Maryland Usual Rasidenca of Dacedant the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar mast be notified at 10d. Insida City Limits Director 1 X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or items 23s 21206 United States 5113 Benton Heights Avenue Funeral 12. Wes Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - American Indian, Black, White, atc. 1 ☐ Yas 2 X No If Yas, Give Yaar or Detes: 1 Navar Married 2 Merrled 1 ☐ Yas 2 ☑ No p Specify: 3 X Widowed 4 ☐ Divorced White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n. any Injury or other traumasis. Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Fether's Nema (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Stanislava Cherry Cuipinski Peter 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Coda) Abingdon, MD 21009 Mrs. Alberta W. Erhardt / Daughter 3123 Birch Brook Lane 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burlal 2 ☐ Crametion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 4/23/1998 Baltimore, Maryland Holy Rosary Cemetery 21. Signatura of Funaral Servica Licansee Michael E. Canapp 22. Nama end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final diseese or condition rasulting in daath) reboro vascular Acciden-**Examiner** Dua to (or es e conseguança of) Physician/Medical Examiner physician and the bunal-transit The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Causa (Diseese or Injury that initiated evants rasulting in death) Last Due to (or es a consequança of) P.O. Box 68760. Dua to (or as a consequenca of): Part II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Tyes 200 No 3 Probably 4 Unknown signed t Division of Vital Records, Completed by 24a. Wes en autopsy performed? 24b. Ware eutopsy findings eveilable prior to completion of cause of daath? page 2 s 1 Yas 2 1 No 1 ☐ Yas 2 ☐ No cartificate Hospital or Attending Physician:
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2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at tha tima, data and placa, and dua to tha causa(s) end mannar statad. Medical 29a. Certifier 29b. Signatura and titla of sertifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and eddrass of parson who completed causa of daath (Item 23a) (Type, Print) 6700 Osler Suite 203 TOWSON MD 21204 FAHED Kou/I M.D Drive

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

APR 2 2 1998

32. Registrer's Signatura

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State of Maryland / Department of Health and Mental Hygiene

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Demit. Page Department of Important: If	any inju	1	21. Signature of Fune al Service License Rohald S. W	åde, Dire	ctor	22. Name and Addr State Ar	ess of Facility Bo	ard, 655 and 21201	W. Balt	imore	e Street
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			30. Name and address of person who cor	pleted cause of de	eth (Item 23e) (T	ype, Print) W. Entan	32158 Street		11		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#23b,24a,26 per Phy G758 4/22/98 EW . Decedent's Neme (First, Middle, Last) Date of Deeth Month 3. Time of Death Dev Yeer **Physician** 15, 1998 7:00PM APRIL DANIEL W. WELLER JR. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 10850 GREEN MOUNTAIN CIRCLE, APARTMENT 3A COLUMBIA Birthplece (Stete or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours NOM 20 F APR. 21, 1916 PENNSYLVANIA Director 219-14-9042 8 Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f ahov must be notified at 1 Yes 2 No Director MARYLAND HOWARD COLUMBIA 10g. Citizen of What Country? 10e. Street end Number 10f Zin Code 21044 U.S.A. 10850 GREEN MOUNTAIN CIRCLE, APT. 3A Funerai 7 is marked other than "natural", or items traumatic avent, the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. ☐ Yes 2X No f Yes. Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BOWING AIRCRAFT Elementery/Secondery (0-12) College (1-4or 5+) COMPANY ENGINEER 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) . Pages 1 end 2 should be filt ment of Health and Mental Hy lant: If item 27 is marked oth jury or other traumatic avent DARL KIFER DANIEL W. WELLER SR. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 11649 FARSIDE ROAD, ELLICOIT CITY, MD 21042 JUDY A. MUNN, DAUGHTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 4/18/98 COLUMBIA, MARYLAND 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 etions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ceuse on each line. Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or comshock, or heart feilure. List only Physician /Medical Immediate Cause (Finel ears Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): eroy. 0 Due to a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 € Unknown Ś 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause 1X Yes 2 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Be Hospital: 1□ Yes 2□ No Other: 4 Nursing Home 5 Pesidence 8 Other (Specify) Certification: To 1 Inpatient 2 Den Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 1 Waturel 5 Pending investigation

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Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760, After this or Attanding death. efter deatl filled in by Hospital 24 hours completely within 2

Registrar

30. Neme end address of perso State

2 Accident

3 ☐ Suicide

29a, Certifie

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4 Homicide

(Check only one)

29b. Signeture end title of cartifier

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29c. License number

🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated.

1 TYes 2 □ No

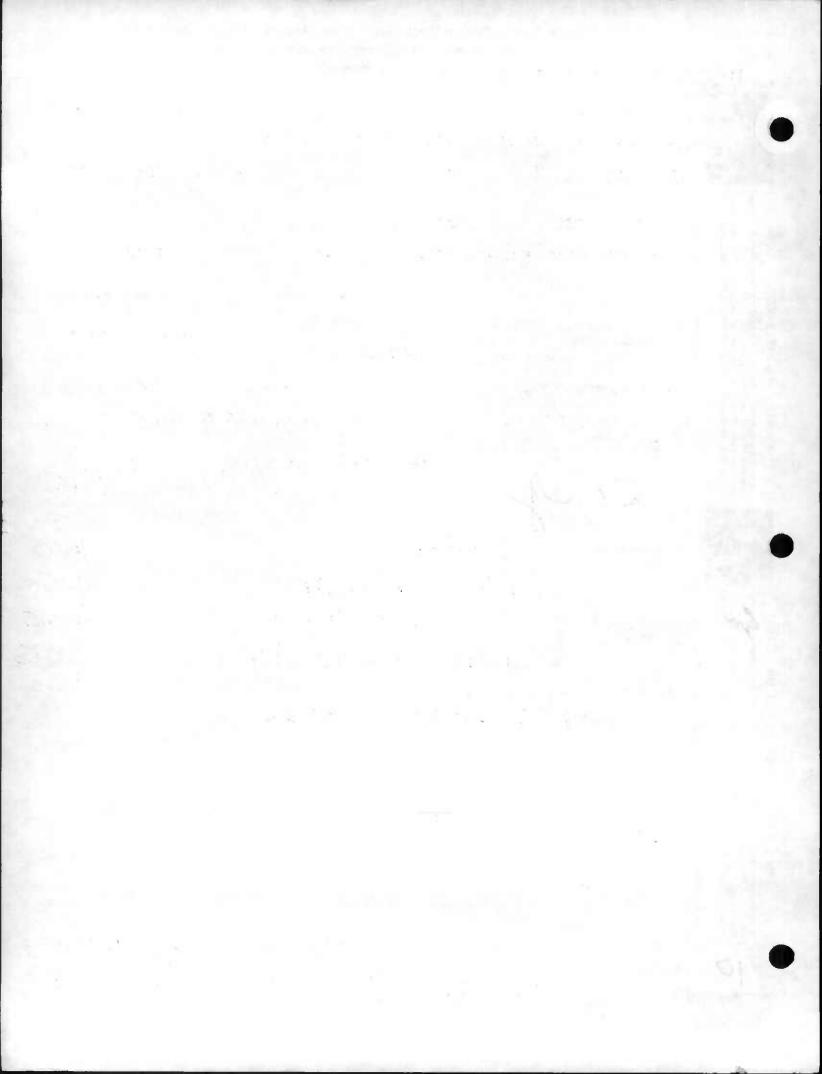
29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

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28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First Middle Last) 2. Date of Death 3. Tima of Daath **Physician** A PRth. Day 1998 Yaer 7, MARGARET BURKE 12:55 PM /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Daath Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | JULY | 8, 1911 | 9. Birthplaca (State or MARYLAND) 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthplaca (State or Foreign **Funeral** 1□ M 2 🔀 F 212-10-0770 86 Director Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. BALTIMORE BALTIMORE Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? rai", or items 23a or Examiner must be a 924- ST. AGNES LANE 21207 USA permit. Pagas 1 and 2 should be filed within 72 hours attar daath v. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, Inc Medical Examiner mass once. Funerai 12. Wes Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2X No It Yas, Giva Yaar or Dates: Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yas 2 ☐ No Specify: Completed by 3€Widowad 4 Divorcad 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) College (1-4or 5+) PHONE EMPLOYEE TELEPHONE CO. 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be THOMAS S. WARD GERTRUDE H. BELL 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) REV.DR.REICHARD-EXECUTOR 9701-VEIRS DR., ROCKVILLE, MD. 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata Data METROPOLITAN CREMATORY-4/8 ALEXANDRIA, VA. 1 Burlal 2 Cramation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Spacify) 22. Nama and Addrass of Facility HYSONG CO., INC. 23a. Part1. Entar tha disaes shock, or haart failure. 1300- N STREET, NW, WASH., DC utions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximete Intervat Batween Onsat and Deeth **Physician** immediata Causa (Final disaasa or condition rasulting in death) /Medical **Examiner** Physician/Medical Examiner The law requires that the death cartificate be executed attanding physician and for usa as the bunal-transit Sequantially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disaase or Injury Box 68760, that Initiated avants resulting in death) Lest Dua to (or as e consequança of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. eup 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 1-No 3 Probably 4 Unknown p Completed 24b. Ware autopsy tindings available prior to 24e. Was an autopsy parformed? complation of cause of death? 2 10 No 1 Yas 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa retarred to medical axeminar? 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Rasidance 6 Othar (Spacify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Manner of Deeth I Director: Aftar ti ed in by the funare 28a. Data of Injury (Month, Day Yaar) Certification: 28d. Describe how injury occurred 1 Netural 5 Pending Invastigation 1 🗌 Yas 2 No daath 2 Accident 6 Could not ba 3 Suicide 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28t. Location (Straet and Number or Rural Route Number, City or Town, Stete) filled in by datarmined after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital edicai 29a. Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and ptace, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who complated causa of death (Item 23e) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year)



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Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month G. APRIL 7,1998 BECTON 7:00pm 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 23,1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 □ M 2 □ X F 89 Yrs 243-07-9318 ROXBORO NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGES TEMPLE HILL 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 4300 BEAMON PLACE 20748 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACK 3 N Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) DOMESTIC PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) DANIAL GILLIS ANN LAWSON 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SAM BECTON / SON 4300 BEAMON PL TEMPLE HILLS MD 20748 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State Dete tXXBurial 2 ☐ Cremation 3 XX emovel from Steta 4-11-98 4 ☐ Donetion 5 ☐ Other (Specify) GLENVIEW CEMETERY DURHAM N.C. 21. Signeture of Funerel Sarvice License 22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOMES 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlec or respiretory errest, shock, or heart feiture. List only one cause on aech line. 2617 PENN. AVE S.E. WASHINGTON DC 20020 Approximate Intervel Between Onset end Deeth Immediate Cause (Final Acute Gres lodans Congestive
Due to (or es e consaquance of) 2-3413 Sequentielly list conditions, if eny, leeding to immedieta ceusa. Entar Underlying Cause (Disease or Injury that initieted events rasulting In deeth) Lest Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 NO 3 Probably 4 Unknown Diabetes. 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cesa referred to madical 26. Pleca of Deeth (Check only one) Hospitel: 1 Minpatient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Yes 2 No 6 Could not be datermined 28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and piece, and due to tha ceusa(s) end mannar as stated.

2 Madicel Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred et the time, date end piece, end due to the ceuse(s) end menner statad. 29b. Signature end title of certifier 29c. License number

Records. P.O. Box 68760. Division of Vital

physician been signed by should be detac certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifice

Physician

/Medical

Examiner

Funeral

Director

? Is marked other than "natural", or Nems 23s or 28s-f shor traumatic event, the Medical Expreser mast be notified at

permit. Peges 1 end 2 should be filed within 72 hours after to Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or thei any Injury or other traumatic event, the Medical Examina-

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Medical Certification:

Baltimore, Maryland 21215-0020

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31. Dete filed (Month, Dey, Year)

27. Menner of Daath

2 Accident

3 Suicide

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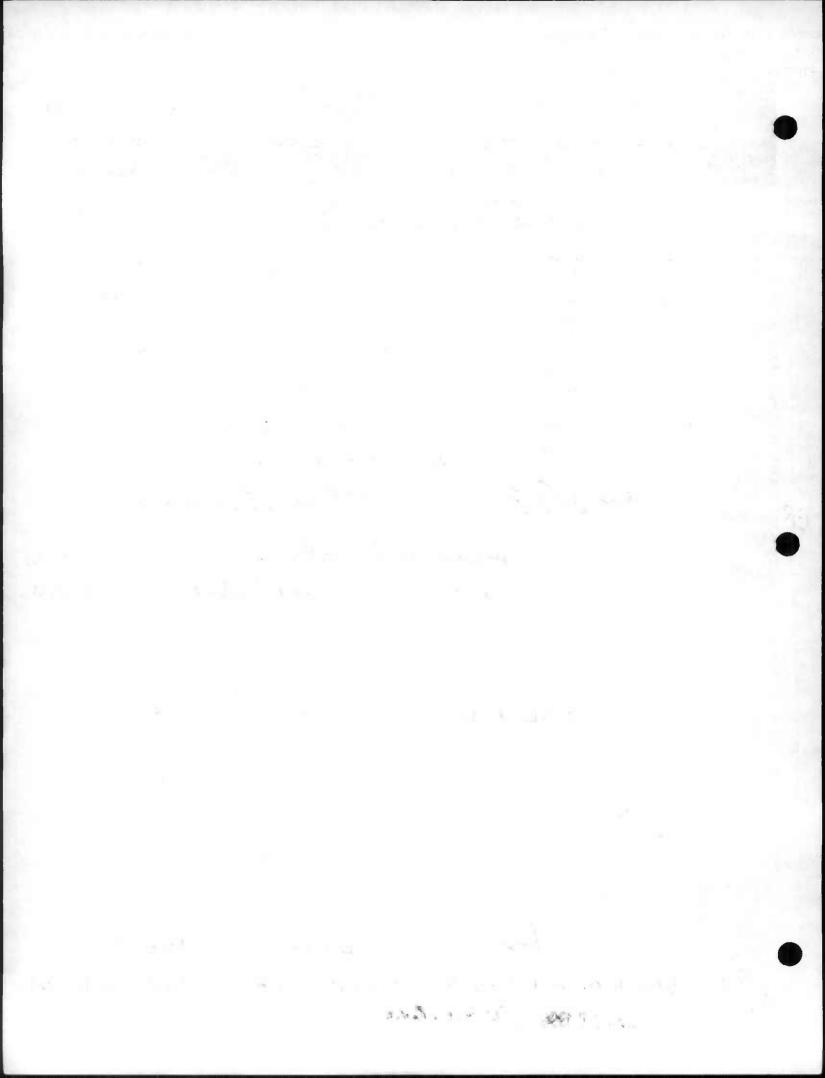
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29d. Date signed (Month, Dey, Year)

30. Nema and address of person who completed cause of death (Item 23e) (Type, Print)

7501 Surratts Rd # 307. Clinton MD20735 patelmo buresh A.

32. Registrer's Signeture APR 1 0 1998



State of Maryland / Department of Health and Mental Hygiene

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23a or 28g	al Direc	10e. Street end Number 2900 Brightsea	at Road #10	1	10f. 2	Zip Code	20706		10g. Citizen of	Whet Country? JSA	
urs after des al', or items Examiner m	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes:	er In U,S.		cedent of H becify Cube 2√2 No	lispenic Origin? (S en, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	0- 14. Rad Bie Specif	ca - American Indick, White, etc. y: Blac	
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hysicia the bur		Immediate Cause (Final disease or condition resulting in deeth)	hai	7 .							
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Deeth 1. Decedent's Nama (First, Middle, Last) Month **Physician** COX BOONE LUVENIA /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner PRINCE GEORGES 6306 CAFON STREET SEAT PLEASANT 8. Data of Birth (Month, Day, Ye June 30, 7. Aga (In yrs. lest birthdey) If Undar 1 Yaer Birthplaca (Stete or Foreign Country) 5. Social Sacurity Number 6 Say Year) 1929 South Carolina **Funeral** Months Days Hours 1 □ M 2 X F 579-34-3538 68 Yrs Director Usual Rasidanca of Decedent the Maryland 10d. Inaida City Limits 10a. Stata 10c. City, Town or Location Seat Pleasant Maryland Prince George's 1 X Yas 2 □ No Directo 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda with an "natural", or items 23e or Medical Examiner must be 6306 Capon Street 20743 USA permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e and hijury or other treumatic event, the Medical Exercises 200.000. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Rece - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 XNo If Yas, Giva Yaar or Detes: 1 □ Nevar Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yas XXNo Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Dacedent's Usual Occupetion 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) 12th Private Homemaker 18. Mothar's Nama (First, Middle, Maidan Surnama) 17, Fathar's Nama (First, Middla, Last) UNKNOWN Annie Mae Wise 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) Martha Malone/Daughter 6306 Capon Street, Seat Pleasant, Maryland 20743 20a. Mathod of Disposition 20b. Placa of Disposition (Name of camatary, cramatory or other place) Data 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cramation 3 ☐ Removel from Stata Arlington National Cem. 4/10/98 Arlington, Virginia 4 □ Donation 5 □ Othar (Specify) 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Fecility J. B. Jenkins Funeral Home Bowma 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Charles I Approximata tntarval Between Onsat and Death **Physician** Immadiate Causa (Final disaase or condition resulting in daath) /Medical CONGESTIVE HEART FAILURE **Examiner** Physician/Medical Examiner ARTERIOSCLEROTIC CARDIOVASCULAR PISEASE physician and tha buriel-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to Immediate cause. Enter Undarlying Causa (Disaesa or Injury that Initiated evants rasulting in daath) Last Dua to (or es a consequança of): P.O. Box 68760. Dua to (or as e consequanca of): usa signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other stanfficant conditions contributing to death but not resulting in the underlying cause given In Part I. 4 Unknown 1 Yes 2 No 3 Probably LIVER DISEASE Division of Vital Records, δ 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performad? Completed RENAL DISEASE completion of cause of death? has iis certificate ha 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa refarred to madical axaminar?
1 Yas 2 □ No Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 □Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28a. Dete of Injury (Month, Day Year) 28c. tnjury et Work? Netural 5 Pending invastigation n 24 hours efter death.

• Funeral Director: Al daath. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated edicai pletely 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) and manner stated. (Check only one) To the To the To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and addrass of person who complated causa of deeth (Item 23e) (Type, Print) GOLLE CHEVERLY MARYLAND 20785 3001 HOSPITAL MARIO

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DHMH 16 Rev 6/95

Registrar

31. Data filad (Month, Day, Year)

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020	filed within 72 hours effer deeth with the Maryland Hygiene. ther than "naturel", or flems 23s or 28s-f show ent, the Medical Examiner must be notified at	by	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tas 2 If Yas, Giva Yaar or Dat	as? XIXIo	1	Vas Dacedant f Yas, specify 1 ☐ Yas 2🏋	Cuban, Ma	lc Origin? (Sp ixican, Puarto ecify:	pecify Yas or No- Rican, atc.)	Bia	ce - Amaric ck, Whita,	atc.
Baltimore, Maryland 21215-0020	within 72 ho iena. than "natur tha Medical	Completed	15. Decedant's Ec (Specify only highast gra Elamantary/Secondery (0-12)	lucation da <i>completed)</i> College (1-4	for 5+)	(Giva lifa. L	lant's Usual O kind of work d DO NOT usa n	ona during atired)	most of work	king	16b. Kind of B		
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Sulcida 6 Could not be datamined	28a. Place o	f Injury - At h	oma, farm, stre (y)				28f. Location (S City or Tow	Street and Numi m, Stata)	ber or Rura	l Routa Number,
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month JOHN MILTON BRANDFORD APRIL /Medical 4e. Fecliity Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Doctor's Community Hospital Lanham Prince George's | Months | Days | Hours | Min. | Mar. 27, 1934 | Hall, 5. Social Sacurity Number 6. Sax. 123 M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-30-2726 64 Yrs. Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Bowie Director 1 TYas 2 □ No must be notifie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20715 4804 Collington Road U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indien, Bleck, White, atc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: ò Specify:Black 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Private Industry College (1-4or 5+) Carpenter 17. Fether's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) un and Mental h Pages 1 and 2 should be nent of Health and Mental Charles Brandford Carrie Snowden 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rutal Route Number, City or Town, State, Zip Code)
4804 COILINGTON ROAD
BOWIE, MD 20715 Important: If Item 27 is a any injury or other Juanita M. Brandford 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town. Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata Harmony Memorial Park 4/8/98 Landover, MD 4 □ Donetion 5 □ Other (Specify) 22 Name end Address of Fecility Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E. 21. Signatura of Funerel Sarvice Licensee Washington, DC 20019 le or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or rasplratory arrest, List only one cause on each line. Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Ventricular fibrillation Jasystole Examiner Due to (or es e consequence of): heart failure conges tive 4 cm I or Attending Physician: The law requires that the death certificate be executed effecteath.

Director: After this certificate has been signed by the attending physician and in by the funeated director, page 2 should be detached for use as the buriat-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): atherosclerosis Box 68760. Dua to (or es e consequence of): Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown rena þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2000 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Nanatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 200No 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled Medical 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. Attending Physician 29c. Licansa number 29b. Signature and title of certifier 29d. Data signed (Month, Dey, Year) David a. Boetchu, m.O. 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) David A. Boeteber, M.O., 14300 Gallant Fox lu. +118 Bowie 31. Dete filed (Month, Dey, Yeer) 32. Begistrer's Signeture State Registrar APR OF 199

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedant's Neme (First, Middle	e, Last)		Certifica			2. Dete of De		Year	3. Time of Deeth	
nysician	Mary Catherin	e Brink					Month April	4, 199		4:00 a.m	
Medical xaminer	4a Facility Nama (If not institution		r)			4b. City, Town, or	Location of Death		nty of Deeth		
Adminici	Sacred Heart H	ome				Hyatts	ville	Prin	ce Geo	orge's	
neral	5. Social Security Number	6. Sax 7. A	ga (In yrs. k		er 1 Yaar	If Under 24 Hrs	8. Date of Bir			pleca (State or Foreign	
ector	577-58-9276 Usuel Residence of Decedent	1□ M 2ሺ F	92	Yrs. Month	s Deys	Hours Min	May 29	1905		sylvania	
	10a. Stete 10b. County		10c. City	, Town or Location						10d. Inside City Limits	
Director	Maryland Princ	e George's	Нуа	attsville						1)X) Yes 2 □ No	
Olre	10e. Street and Number			10f. 2	Zip Code			10g. Citizen o	of Whet Cou	ntry?	
a L	5805 Queens Cha	pel Road			2078	2		U.S.	Α.		
by Funeral	11. Marital Stetus 1 □ Never Married 2 □ Marria 3 □ Widowed 4 ☒ Divorced	If Vac Give	?] No			lispenic Origin? (S an, Mexican, Puer Specify:	Specify Yas or No to Rican, etc.)	Spen	lace - Americal Americal Americal American Medical Med	etc.	
1	15. Deceden	t's Education		16e. Decedent's U (Give kind of life. DO NOT	suel Occup	ation	arkin a	16b. Kind of	Business/In	idustry	
Completed	(Specify only higher Elementary/Secondery (0-12)	College (1-4or	5+)	life. DO NOT	use retire	duning most of we	iking				
5	12			Clerk -	Typi					vernment	
Be (17. Fether's Neme (First, Middle,	Last)				18. Mother's Ne	ma (First, Middle,	Maiden Sum	eme)		
2	Anthony McHugh					0	t A. McD				
	19e. Informent's Name/Reletions								City or Town, State, Zip Code)		
	Mary C. Smith -	Daughter		2805 63rd					2078		
	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion	3 □ Barnoval from State	20b. Pl	ece of Disposition (formetery, cremetory of	r other ple	ca)	Dete	20c. Locatio	n - City or T	own, State	
	4 □ Donetion 5 □ Other (S		Gat	e Of Heav	ren Ce	emetery	4/7/98	Silver	Spri	ng, Maryla	
	21. Signature of Funerel Servica Claude 23a. Pert1. Enter the disease, or shock, or heert failure. List	tte d.	ad tha daeth	Gascl 4739	l's F		enue, Hy		11e, N	D 20781 Approximete Intervel Batween	
Examiner	Immediate Ceuse (Final diseese or condition resulting in death)			es e consequenca d						onset and Deeth 3 Weeks 3 Weeks 4 Cars	
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LYG	if eny, leeding to immediate	Seni		1						y lars	
edicai	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	d.	-	as a consaquanca o	(a					1 3	
Cla	Pert II. Other significant condition	ane contributing to death	but not recu	ting in the underlyin	n cause on	ren in Pert I	23h Did	tobacco usa	contribute	to the cause of death	
Dy rellysicial pin	None	Ans contributing to death	DU(110(1850	ing in the orderlyin	y cause yn	veri in reiti.		Yes 201		obably 4 Unknow	
a posidino								en autopsy omed?	61	Vere eutopsy findings veileble prior to ompletion of cause f deeth?	
;	2						1 🗆	Yes 3DM	1	☐ Yes 2☐ No	
Be	25. Was case referred to midical axaminar?					26. Plece of De	eth (Check only	one)			
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	27. Manng of Death 1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi		jury Jey Year)	28b. Time of Injury M	28c. Inju Wo 1 🗆	ry et rk? Yes 2 □ No	28d. Describe	how Injury oc	curred		
	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inact 286. Placa of II	njury - At ho etc. (Specify	me, ferm, street, fec	ory, offica			Street end Nu wn, State)	imber or Rui	ral Route Number,	
edical Certification:		g Physician: To the bes Examiner: On the basis and menner:	of exeminati								
Me	29b. Signature and title of ceglile	1	1		29c. Licens	se number		29d. Date sig	ned (Month	Dey, Year)	
	to the hal	Der			1	2278	2	4/1	199	?	
	THE PROPERTY OF THE PARTY OF				U	7770		11	11		
	20 Name and address	una namelated access of	dooth /te-	220) /Time Dilat							
Medical Cert	30. Name end address of person Peter Schissler			23e) (Type, Print) enway Cen	tor D	rive #1	20 0	-h - 1 -	MD	20770	

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3 Time of Death Month **Physician** Jennie Angela Bottazzi 4, 1998 April 9:55 pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sligo Creek Nursing & Rehabilitation Center Takoma Park Montgomery 6 Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign
Country) 1□M 2XF Months Days Hours 579-03-0246 89 June 24, 1908 Washington, DC Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 X Yas 2 No Director Maryland Prince George's University Park 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4429 Underwood Street U.S.A. 20782 Funerai 11 Marital Status 12. Was Decedant Evar In U.S. Was Dacedant of Hispanic Orlgin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Armed Forcas?
1 ☐ Yas 2 ☒ No if Yas, Give Bleck, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: Specify: White þ 3 ☑ Widowad 4 ☐ Divorcad Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collega (1-4or 5+) Insurance Examiner Federal Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Carmelo Milice Catalano Angela 19a, Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1303 Lavall Drive, Davidsonville, Maryland 21035 Joseph C. Bottazzi - Son 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramovai from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) Mount Olivet Cemetery 04/08/98 Washington, DC 21. Signature of Funaral Sarvice Licansaa 22. Name and Addrass of Facility
Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximata intarval Batwaan Onsat and Daath Immediata Causa (Final disaasa or condition resulting in daath) a Insulin Dependent Diabetes Mellitus 10 Years Dua to (or as a consequence of): Stroke 6 Months Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disaasa or Injury that initietad avants Dua to (or as a consequence of): Coronary Artery Disease 10 Years Physician/Medical that initietad avants rasulting in daeth) Last Dua to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☑ No 3 Probably 4 Unknown Hypothyroidism þ 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy performed? complation of causa of death? 2 X No 1 ☐ Yas 1 ☐ Yes 2 ☐ No Be 25. Was case rafarrad to medical 26. Placa of Daath (Check only ona) axaminar? Other: 4 ☑ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 10 1 Yas 2 No 1 inpatiant 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 X Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarminad 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 \(\text{Homicida} \) 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Medical 29a, Cartifian 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) April 7, 1998

within 24 hours effer To the Funeral Dir

Funeral

Director

Items 23a or 28a-f show

permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health end Mentel Hygiene. I important: if Item 27 is merked other than "natural", or item any injury or other traumatic event.

Physician

/Medical

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signed by the all

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After this

Director: /

Hospital or Attending Physician:

death.

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Examiner

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

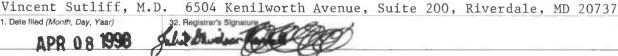
death with the Maryland

State Registrar

APR 08 1998

31. Dete filed (Month, Day, Yaar)

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)



DHMH 16 Rev 6/95

LANGE CONTRACTOR OF SHARE

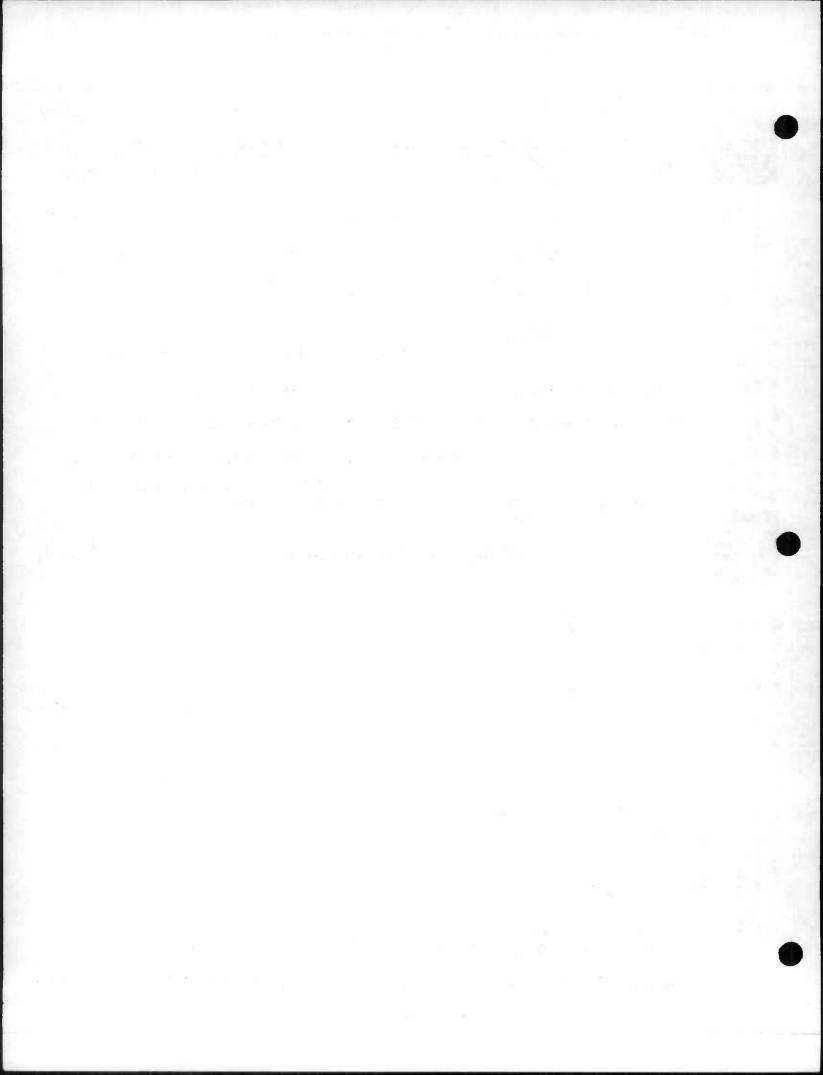
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Robert BARNES 10 pm April 199 x /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 19, 1937 6. Sex 15 M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 412-52-9150 Yrs. 61 Director Tennessee Usuet Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Howard Director Sykesville 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 12505 Indian Hill Drive items 23s 21784 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Ortgin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of neat of Health and Mental thygiena. Int. If New 27 is marked other than "natural", or iten Iny or other traumatic event, the Medical Examines. 1 XYes 2 No If Yes, Give Year or Dates: 1955–59 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Service Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mitchell Guy Barnes Virginia D. Pitcock 19a. tnforment's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn Barnes (Wife) 12505 Indian Hill Road Sykesville, MD 21784 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Crestlawn Mem. Gardnes 4/6/98 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finat 5 Weeks Malignant Mesotheliouna disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Records, P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): 88 USB signed by the a Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? ate has l cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 28e. Date of tnjury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1. Naturat 5 Pending 1 Yes 2 No Investigation 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 29a. Certifier 🗠 Cartifying Phyaictan: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. within 2 To the å 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) hubulus W. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
NICHOLAS WI- KONTRELIAKOSMI) 11065 Li HIC PARLISERT PKM, CI INNULIN MD 21044 33. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 08 1998 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dale of Deeth 3. Time of Death 1. Decedent's Neme /First, Middle, Last) Month **Physician** 12:00 Bentivegna James Vincent /Medical 4b. City, Town, or L cation of Deeth Facility Neme (If not institution, give street end number **Examiner** nklin If Under 1 Yeer If Under 24 Hrs. Security Number (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min XXM 2 F Yrs. 1911 New York Director 051-09-2112 16, Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number r than "natural", or items 23s or the Medical Examiner must be r 21015 USA 2014 Robertson Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merital Stelus Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White py 3 ₩idowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shop Foreman Electronic 10 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be (nmn) Ignatius Bentivegna (nmn) Pumilia Lucy 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lucille B. Sonnichsen/Daughter 108 Victory Lane, Bel Air, MD 21014 Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Burial 2 Cremation 3 ☐Removel from State 4-6-98 Fallston, Maryland 4 🗆 D n 5 Done Highview Memorial Gardens cify) of Funeral S 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 o not enter the mode of dying, such es cardiac or respiratory errest, Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpalient 3 DOA 27, Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide

Examiner The law requires that the death certificate be axecuted attanding physicien end for use es the buriel-tran Division of Vital Records, P.O. Box 68760, ed by the a signed by t been si page 2 s certificate Hospital or Attending Physician: this funaral Aftar n 24 hours efter death.

Ne Funeral Director: Al death. Medicai completaly within 2

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Pages 1 and 2 riportant: If Iham 27

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6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and file

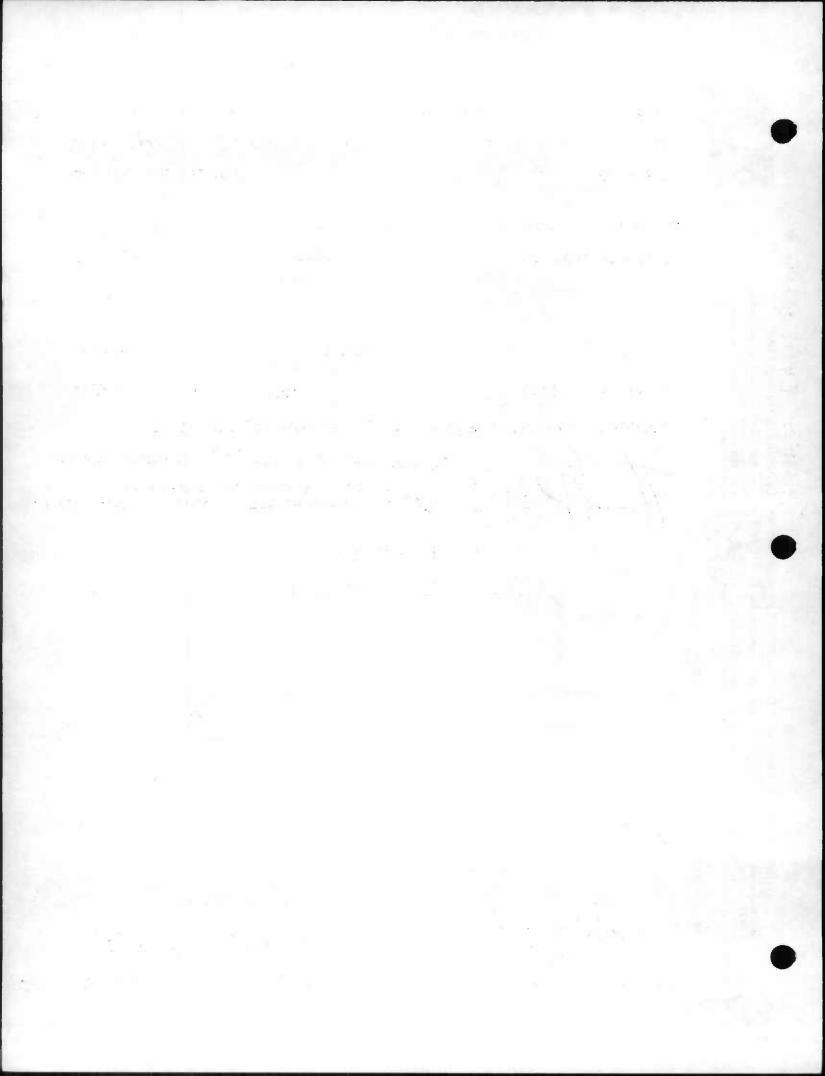
29d. Date signed (Month Day, Year) 29c. License number

30. Name end ddress of p mo completed cause of deeth (item 23e) (Type, Print)

rs Signature Randall

State Registrar

31. Dete filed (Month, Dey, Year) 32 Registrar's Signature 1998 2R6



State of Maryland / Department of Health and Mental Hygiene

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Vlai	and Mental s marked o	To	James M. C	hilds				Reber	ca f	Det44				
Maryland	2 8 8	ľ	19e. Informent's Name/Reletionship (Type, Print)	15	b. Melling Addr	ass (Street	end Number or Run	Routa Numb	er, City or Town,	Stete, Zip	Code)		
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0	aling Ph After th funeral		27. Manner of Death 1 Neturel 5 □ Pending	28e. Dete of Injur (Month, De)	ry 28b.	Tima of Injury	28c. Injur Wor			how Injury occur				
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	(/1)		Samo	10/1/	awi		1)3	4276	+	4-10	9 - 0	98		
	(1)		30. Neme end address of person who	completed ceusa of de	aath (Item 23e)	(Type, Print)	-		. ^/	1 1	inster	98 1, ma x235- Ave.		
			SAM TELLAWI, M		-			7700	010	1 1510	inch	Ave.		
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registry	de Signature									

APRIUMOS John Manufales

State of Maryland / Department of Health and Mental Hygiene | |

Certificate of Death

	Physic /Medi		1. Decedent's Nama (First, Middle, I	est) CARTER				2. Data of D Month MARCH	Dey	Yaar	3. Tima of Death 9:00 AM
Ĺ	Exami	ner	4a. Facility Nama (If not institution, g	AY CT.		If Undar 1	TEMPLE		PRINC	y of Death E GEORG	
	Funeral Director		5. Social Security Number 578-20-1460 Usual Residence of Decedant	Sax 7. Aga (In	yrs. last birthday 79 Yrs.			Min. (Month, L	Day, Year)	9. Birthplac Country, WASHIN	a (Stata or Foraig GTON, D.
	the Maryland 28a-f ahow notified at	tor	10a. Stata 10b. County	GEORGE S	City, Town or L					10d.	insida City Limits
	or 28a	Directo	10e. Street and Number			10f. Zip 0	Coda		10g. Citizen of	What Country	?
	23a c		4322 23RD. PAR	KWAY CT.		2	0748		UNITED	STATES	
020	be filed within 72 hours aftar death with the Manyland tal Hygiena. d other than "natural", or items 23s or 28s-f show event, the Medical Example must be notified at	by Funeral	11. Maritel Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedant Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		If Yas, specif	nt of Hispenic Origin y Cuban, Maxican, F No Specify:	? (Specify Yes or N Puarto Rican, etc.)		ca - American ck, White, etc. fy: BLAC	
21215-0020	vithin 72 na. han "nat	Completed	15. Decedant's (Spacify only highest g Elementary/Secondery (0-12)	Education rada complatad) College (1-4or 5+)	(Give	edant's Usual a kind of work DO NOT usa	done during most or retired)	f working	16b. Kind of E	Businass/Indus	try
Maryland 2	12 should be filed v and Mental Hygie I a marked other t raumatic event, to	To Be Co	17. Fathar's Name (First, Middla, La: GEORGE CARTER	it)	ПО	TIL TIAK		Nama (First, Middl	a, Maiden Suma	ma)	
lan	s 1 and 2 should Health and Mer tem 27 is marks other traumatic		19a. Informant's Name/Ralationship	(Type, Print)	19b. Meil	ing Address (Street and Number of	or Rural Routa Num	ber, City or Towr	, Steta, Zip Co	ide)
	2252		FRANCIS L. CART		4322		PARKWAY		LE HILL		
altimore,	00-		20a. Mathod of Disposition 1 Burial 2 Crametion 3 4 Donation 5 Other (Spec	☐Ramoval from State	b. Place of Disp camafary, cra LINCOLN	matory or oth	ar placa)	Data 4/6/98	SUITLA	Olty or Town.	
Balt	permit. Pag Department Important: If any injury o		21. Signature of Funaral Sarvice Lic	Pure MOR		ALEXAN	Addrass of Facility DER S. PO ARLBORO P	PE FUNERA	L HOMES	MARYLA	ND 20747
	Physician		23e. Pert T. Entar tha diseasa, or co shock, or heart failure. List only	mplications that caused that of yona cause on each line.						Ac Int	oproximata tarval Between nset and Death
	/Medicai Examiner		immediate Causa (Final disaase or condition resulting in death)		vasc to (or as e consa		Acci	dent		/	Dyrs
, O	cate be executed physician and s the burial-transit	Examiner	Sequantially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated avants	b. — Due t	o (or es a conse	quance of):					
c 68760,	ath certificate be executed ttending physician and or use as the burial-transit	an/Medical	Cause (Disaasa or injury that initiated avants rasulting in daath) Last	C. Dua ti	o (or as a consec	quence of):					
Box		lan		d							
, P.O.	y the	by Physic	Part II. Other significent conditions	contributing to death but not	resulting in tha u	andariying cau	isa given in Pert I.		Yes 2 No		e cause of death
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Ž	The ate h	Com						1 🗆	Yas 2 No	1 □ Y	as 2 No
Vital	Physician: The this certificate ral director, par	Be	25. Was casa raterred to madical axaminar?	tannia.				Deeth (Check only	ona)		
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Division	tending leath. tor: After the funa	Certification:	1 Naturel 5 Panding 2 Accident invastigati 3 Suicide 6 Could not	be l		М	c. Injury at Work? 1 ☐ Yas 2 ☐ No		how injury occu		
$\overline{\Sigma}$	al or Attend s after death il Director: / ed in by the	Sertifi	4 Homicide datamine		At homa, farm, st ecify)	raat, factory,	office	28f. Location City or To	(Street end Num own, State)	ber or Rural Re	outa Number,
	Hospital or At 124 hours after of Funeral Direct letely filled in by	dical (29a. Cartifiar (Check only one) Condition Condition	hyeiclan: To tha best of my miner: On tha basis of axam end mannar stated.	knowledga, daat nination and/or In	h occurred et vastigation, in	the tima, data and p my opinion, daath	place, and dua to the	a cause(s) and m	annar as state and dua to the	d. e causa(s)

State Registrar

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S. Mu.D. 10 Box 385 Lancvel Md 20725-0385



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98-1953-031 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene JOSE GILBERTO Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Day **Physician** 1 1998 4c. County of Death /Medical APRIL 06' 23:43 PM 4a Facility Nama (If not institution, giva street and number) Examiner UNIVERSITY BOULEVARD AND 15th AVENUE Social Security Number 6. See 7. Aga (In vrs. last birthday) **Funeral** MM 20F Months Days Hours 35 Yrs. Unknown
Usuai Rasidanca of Decedant Director permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Meryland Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Of. Zip Coda 10g. Citizen of What Country? 10e. Street and Numbe Salvado 2027 Funeral Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) Race - American Indian, 11 Marital Status 12. Was Decedant Evar in U.S. Armed Forcas?

1 Yas 2 No
If Yas, Give Black, White, etc. Nevar Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: Salvadorch þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest grada completed) econdary (0-12) Collaga (1-4or 5+) Elamantary/Se borer 18. Mothar's Nama (First, Middla, Maidan Sumama) 17 Father's Nama (First, Middla, Last) Be OY 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, erru 20b. Place of Disposition (Nama of cematary, cramatory or other p 20a. Method of Disposition Data 20c. Location - City TABurial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) any injury or 21. Signatura of Furant Sarvice Licensaa 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not antar the mode of dying, such as cerdi shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death **Physician** /Medical Immediata Causa (Final Head disaasa or condition rasulting in daath) injunies **Examiner** Examiner requires that the death certificate be executed physicien end the bunal-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad evants rasulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consaquence of): 80 esn 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 Yes 28 No 3 Probably 4 Unknown g 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed hes page 2 1 Ø Yas 2 □ No 1 ☑ Yas 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was cesa rafarrad to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Dothar (Specify) 1 □ Yas 2 □ No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this 28d. Dascribe how injury occurred 27. Manner of Death 28a, Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: After 5 Pending invastigation 1 Naturai 1 Yas 2 No death. -98 unknown To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A 2 Accidant struck b subject Car 6 Could not be dataminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 281. Location (Streat and Number or Rural Routa Number City or Town, Stata) University Blud filled in by 4 Homicida County, Maryland Georges Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medicai completely (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number OCME APRIL 07, 1998 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Radentz 5, Stephen 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Day, Yaar)
APR 0 9 199

32 Ragistrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 1998 APRIL 6, HERBERT COLES 2:00 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death - Silver Spring Silver Spring Manorcare Health Services Montgomery If Under Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, NOV 25, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Months Deys 1√2 M 2□ F Hours 569-09-7649 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d Inside City Limits Silver Spring 1 Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Musgrove Road 20904 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 12 Yes 2 No 1-25-43 1 Never Merried 2 Married 1□ Yes 2√2 No Specify Specify: Black Year or Detes: 9-5-44 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4+ Real Estate & Insurance Broker Self-Employed 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Herbert R. Coles Sr. Hilda Mars 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 67 Kinsman View Circle, Silver Spring, MD 20901 Gina A. Coles - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 48 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 2 weeks disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 215 No 1 ☐ Yes 1 □ Yes 2 □ No 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

MD

Director

Funeral

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Completed

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Funeral

Director

than "natural", or itams 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with t Department of Health and Mentel Hygiene. Important: If Itam 27 is merked other than "natural", or itams 23s or 2 any injury or other traumatic event, the Medical Examples 200.000.

Baltimore, Maryland 21215-0020

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Examiner physician end s the burial-tran Physician/Medical signed by the a id be deteched f by Completed this certificate has Hospital or Attanding Physician: 24 hours efter deeth.
Funeral Director: After this certifica Be 2 Certification:

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Pleural effusion Cevebro Vascular accident

Other: 4 virsing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 Yes 2 No 27. Menner of Death latural 5 Pending Investigation 2/ Accident 3 Suicide 6 Could not be determined 4 | Homicide

31. Date filed (Month, Day, Year)

28a. Date of Injury (Month, Day Yeer) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 🗆 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signature and the

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person

ed couse of death (Item 23a) (Type, Print)

MN 13952: Balhmue Ave, Laurel, MD 2070

State Registrar

Medical

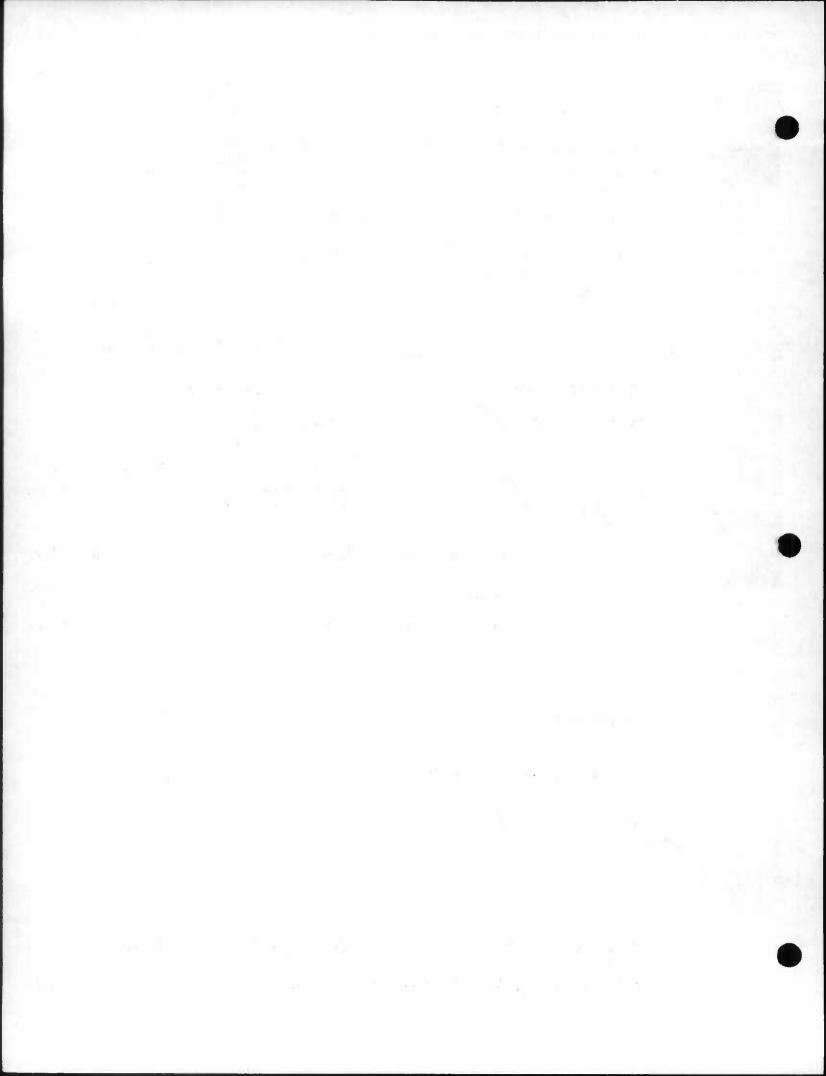
To the Hospital or within 24 hours eft To the Funeral Di completely filled in

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State of Maryland / Department of Health and Mental Hygiene

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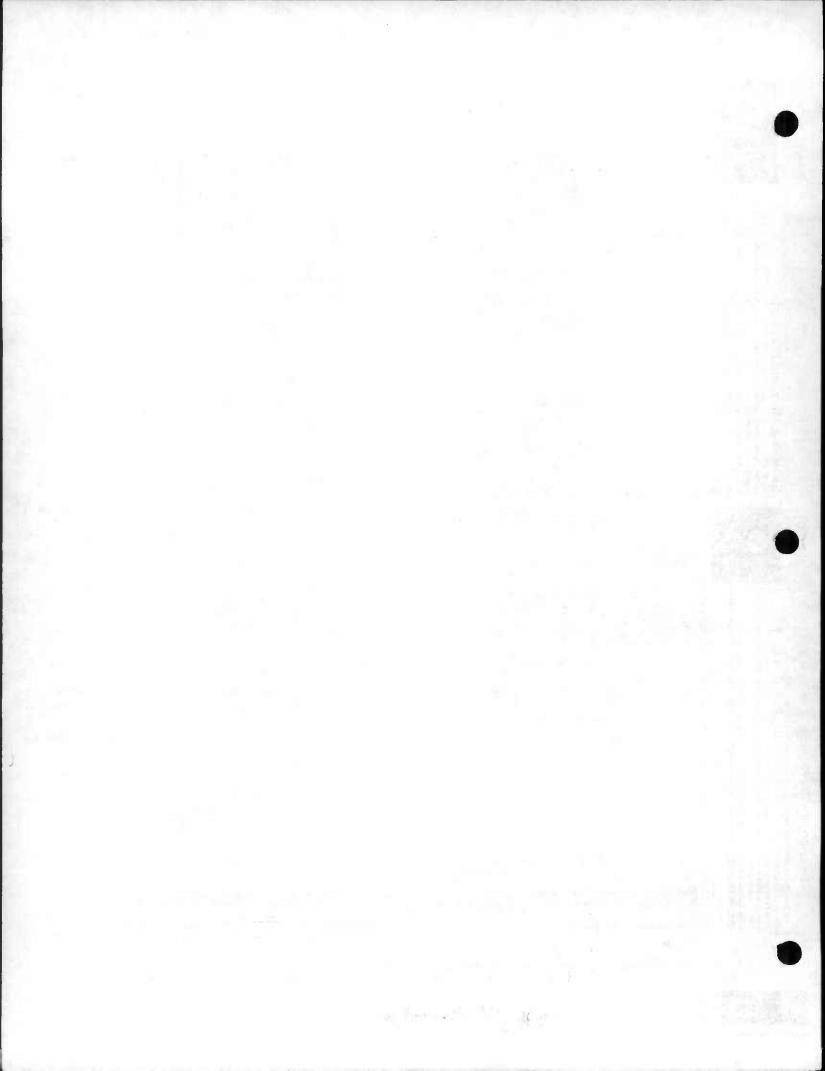
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# 22 #		Director	10e. Street and Number				10f. Zip Coda				10g. Citizen of	What Cou	intry?
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72 hours efter deeth with the Maryland naturel', or Items 23s or 28=4 show		Launerai	11. Marital Status	12. Was Deceden	t Ever In U,S.	13. W	as Decedent of	Hispanic O	rigin? (Sp	ecify Yes or No			ican Indian,
fter he	l li	5	1 ☐ Never Married 2 ☐ Married	Armed Forcas	7 UNO		Yes, specify Cub		n, Puerto	Ricen, etc.)	Bla	ck, White	, etc.
d within 72 hours of glone. wr than "natural", or		2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1	☐ Yes 2万No	Specify	<i>/</i> :		Specif	y: Wh	ite
72 hours natural,	1		15. Decedent's E	ducation	166	Deced	ent's Usuel Occu	nation			16b. Kind of B	usiness/li	ndustry
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르 등 전 느		-	Mr.Marion H.	Chambers		202	Belved	ere	Ave.	, Cent	reville	e, M	ld.21617
of Hes			20a. Method of Disposition 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	Domesial from Otata	an make	of Dispos ery, crem	ition (Name of etory or other pla	ice) A	pril	Date 1 4	998	- City or T	own, State
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90 5	S S		b then lost	100.		F	ellows	,Hel	fenb	ein &	Newnar	n Fu	neral Hore, Md.
		- 4	Jingjorg	cneed	29/	4	08 S.	ripe	rty	St., (Centre	vill	
			23a. Party. Enter the spease, or com shock, or heart failure. List only	one cause on each i	ing death. Do	not ente	r the mode of dy	ing, such a	s cardiac (or respiratory a	rrest,		Approximete Interval Between
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/Medic Examin	_		Immediate Cause (Final disease or condition	mn	ti 5454	cm	tailur	~				į	4-5 hrs
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requires that the death been signed by the atter- hould be deteched for	Dhveirian	2	Part II. Other significant conditions of	ontributing to death i	but not resulting	in the un	derlying cause gi	ven in Part	I.	23b. Dld	tobacco uae co	intribute 1	to the cause of death?
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or Attendent efter deat Director:	=		4 ☐ Homicide determined	building, e	tc. <i>(Specify)</i>	arm, stre	et, fectory, office			City or To		oer or Hur	ral Routa Number,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth 3. Time of Death Month 4 Physician 48° William (058 A /Medical 6 4e. Facility Name (If not institution, give straat and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Long View Nursing Home Manchester f Undar 24 Hrs. 8. D Carroll 5. Social Sacurity Number If Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Birthplace (Stata or Foraign Country) 1 M 2 □ F Hours Months Days Min Yrs. Director 215-96-5331 82 Jul 4, 1915 Maryland Usual Rasidance of Dacadant 10a. Stata 10c. City. Town or Location 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at MD Carroll Director Manchester 1 ☐ Yas ♣☐ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò Long View Nursing Home 238 21102 U.S.A. Funeral Herns Was Decadant Evar in U,S. Armad Forces? 11. Marital Status Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelin and Mental Hygiane. Important: If Itam 27 is marked other than "natural", or its any follory or other transmits event, The Medical Essimina any follory or other transmits event, The Medical Essimina. 1 Never Marriad 2 Marriad ☐ Yas 2☐**X**No f Yas, Giva Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Yeer or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) unknown None 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fethar's Nama (First, Middla, Last) Be 2 Ulyses Grant Cook Mary ALverda Dameral

19b. Malling Addrass (Straet and Numbar or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 125 Stoner Avenue Westminster, MD 21157 Mrs. Gayle Jones (Guardian) 20b. Placa of Disposition (Nama of cametary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Springfield Cemetery 4/7/98 Sykesville, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvica Licensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) near the Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enfer the disease, or complication, thef caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximete Intarval Betwaan Onsat and Death **Physician** Immediata Cause (Final disaasa or condition rasulting In daath) /Medical Mts benen Examiner Dua to (or es a consequence of): Examiner The law requires that the death certificate be executed sician end buriel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that leaf interest as a control of the leaf interest as a control of Dua to (or as a consaquance of): P.O. Box 68760, physician Physician/Medicai that initiated evants rasulting in death) Last use as the Due to (or as a consequence of): for detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ should be 24b. Wara autopsy findings evallable prior fo complation of causa of deeth? Completed 24a. Was en autopsy performed? certificate has page 2 1 Yas 2 No 1 Yas 2 No of Vital or Attending Physician: Be 25. Was casa rafarrad to medicel 26. Placa of Death (Check only ona) axaminar? P 1 Yas 2 No Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA this the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) After t Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Panding Invastigation death. To the Hospital or Attendit within 24 hours efter death. To the Funerel Director: A 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be dataminad 28a. Place of Injury - At homa, farm, straat, facfory, offica building, atc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifian Medicai completely (Check only one) 29b. Signatura and titla of certi 29c. License number 29d. Data signed (Month, Day, Year) W D 33165 98 30. Nama and address of herson who complated ceusa of daath (Itam 23a) (Type, Print) anoser Piter 32. Registrer's Signature 31. Data filed (Month, Day, Year) State Juli Struck Registrar



State of Maryland / Department of Health and Mental Hygiene \

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 1998 Month **Physician** April 2, Margaret B. Darcy 4:25 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6900 97th, Place Seabrook Prince Georges Hours Min. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Days 1 M 2 F 87 Yrs. 075-09-5906 1910 New York Director Usual Rasidence of Decedent tha Maryland 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1□Yes 2□No Director Maryland Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6900 97th. Place 20706 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus permit. Pagas 1 and 2 should be filed within 72 hours aftar of Department of Haalth and Mental Hygiana. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examination. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Private 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) John Maxwell Georgiana Lindsey 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Margaret Lattin (Daughter) 6900 97th. Place Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) St. Josephs Cemtery 4/9/98 Yonkers, New York 22. Neme end Address of Fecility
Rendon/Hale Funeral Home
9013 Annapolis Rd. Lanham, MD 20706 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** CARCINOMA OF BREAST C /Medical Immediate Cause (Finel disease or condition rasulting in daath) Examiner Due to (or es a consequence of): METASIS Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disaase or Injury thet initiated events resulting in daath) Lest and physician the burial Box 68760 8 Physician/Medical Due to (or as e consequence of): 100 811 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2XXNo á 24b. Wera autopsy findings eveilable prior to complation of cause of death? 24e. Was an eutopsy Completed Deen 걸 phge 2 1 □ Yes 2 □ No 1 Yes 2 No centificate 25. Was case rafarred to madical 88 26. Pleca of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residance 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 祖 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending 1 Naturel 5 Pending 1 Yes 2 No death. investigation after death Director: / 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide a Hospital 24 hours a Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Cartifian (Check only one) To the P 29d. Date signad (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Name and address of person who completed cause of daath (Itam, 23a) (Type, Print). 31, Data filed (Month, Dey, Year) 32. Registrar's Signeture

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedant's Name (First Middle Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** 4º BM DAYIS OSEPH AMIC /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner lak PRINCE GEORGE'S aure 5. Sociel Security Number If Under 1 If Under 24 Hrs 6. Se 7. Age (In yrs. lest birthday) Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 10 M 2□ F Days 17-05-406 Yrs Director 90 MARYLAND Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Med cal Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE'S SEABROOK 10f. Zip Code 10g Citizen of What Country? 9813 GOOD LUCK ROAD, APT. #7 20706 UNITED STATES Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other traumatic event. 1 X Yes 2 No 1942 If Yes, Give
Yeer or Detes: 1945 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: g 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry INSTITUTIONAL FOOD Elemantary/Secondary (0-12) Coliaga (1-4or 5+) 12 FOOD BROKER DISTRIBUTION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surneme) WALTER DAVIS PEARL STRAHLER 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) ELIZABETH S. DAVIS, WIFE 9813 GOOD LUCK ROAD, #7, SEABROOK, MARYLAND 20706 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Crametion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4/4/98 FORT LINCOLN CREMATORY BRENTWOOD, MARYLAND 21. Signeture Funeral Service Litense 22. Name and Address of Fecility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errast, shock, or heert feilure. List only one ceuse on each line. Approximete Intervel Between **Physician** /Medicai Immediete Ceuse (Finei ACUTE MYOCANDIAR INFANCTION diseesa or condition resulting in daath) BUUTE Examiner Dua to (or as a consequence of): Examiner Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury thet initiated events rasulting in deeth) Lest and Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Noknown AUZHEIMER'S DISEASE Š 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certific Be 25. Wes case rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 PNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mennar of Daath 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide pelli 24 hours e 29a. Certifier Medical 🔁 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. pletely (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the ceuse(s) end menner stated. within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lo D52455 ~O 30. Name and address of person who completed cause of daeth (Itam 23a) (Type, Print) 14333 LAURE BOLYE RO LAUREL, MD MAGGIN, MD BENT 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

APR 07 1998

A SANTA SANT

State of Maryland / Department of Health and Mental Hygiene ? Amend: 19b Per FH Film G759 5-4-98RC Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 26, 1998 7:50 AM DANIELS March DELORES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) **Examiner** Prince George's Gladys Spellman Nursing Home Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Steta or Foreign Country) **Funeral** 1 ☐ M 2 🗙 F Yrs. Georgia 1919 Director 240-34-7326 78 June 29, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or itema 23a or 28a-f shov poicel Examiner must be notified at 1 1 Yes 2 □ No Directo District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20017 1214 Buchanan Street, N. E. Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Navar Marriad 2X Married 1 Yas 2 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry illed within 72 h Hygiena. 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 9th Housewife Private 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) should be and Mental Rosa Curry Erskine Searles 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20017 19a. Informent's Neme/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 87 1214 Buchanan Street, N.E., Washington, D.C. item 27 I Robert A. Daniels - Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If it any Injury or o 1 Rurial 2 □ Cremation 3 □ Removal from State 4/2/98 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C. 20019 nn 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** MYOTROPHIC LATERAL SCHEROSIS. Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner FAIRURE. Examiner physician and the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. the 3 1 Yes 2 No 3 Probably 4 Unknown by been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? has 1 Yes 1 ☐ Yas 2 ☐ No cartificate Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) An 24 hour.
The Funeral Directory of the Control of 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier edical (Check only within 2 To the I 29d. Data signed (Month, Dey, Year) 29c. License number D-3 4525 29b. Signatura and titla of cartifiar 30. Name and address of person who completed cause of death (Item 23.5) (Type. Print) Wile Road; #220; Bow 16; MD20716

State Registrar

31. Date filed (Month, Day, Year) APR 08 199

32 Ragistrar's Signature

DAZIEFE

277 00 798 AL SALES

AND THE RESERVE SECTION

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 04:17 PM DAVIDSON JAMES APRIL 06 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, giva street and number) PHNCE GEORGES PHNCE GEORGES CHEVERLY HOSPITAL CENTER | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 28, 1 6. Sex 1 X M 2 □ F Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) Months 71 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Laurel 10f. Zip Code 10g. Citizen of Whet Country? 20708 14817 Bowie Road, Apt. #304 U.S.A. 12. Was Decedent Ever in U,S. Armad Forcas? 1 M Yes 2 □ No If Yes, Give Yaer or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Spacify: 3 ☐ Widowed 4 Ĭ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Albert Turner, Inc. Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middla, Last) James Raymond Davidson, Sr. Susan Leland Becraft 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 N. Highland Street, Arlington, Virginia 22201 Mark Gore - Attorney 20b. Piece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Crametion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 4/10/98 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, 23e. Perfi. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart believe. List only one cause on each line. MULTIPLE INJURIES WITH COMPLICATIONS Dua to (or es e consequence of):

Physician /Medical Examiner

physician and the burial-transit

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signed by the a

that the death certificate be executed

or Attending Physician:

Hospital

this funeral

After

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24 hours after deal Funeral Director:

To the To the T

filled in by

completely

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

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Certification:

edical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examples must be a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Madical Examples must

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

with the Manyland

5. Social Sacurity Number

213-24-2891 Usual Rasidance of Decedent

Maryland

10e. Street end Number

6

20e. Method of Disposition

10e. State

Immediate Causa (Final disease or condition resulting in deeth)

equentielly list conditions, any, leeding to immediate use. Enter Underlying suse (Disease or injury at initiated events suiting in death) Last	BLEEDING FROM PANCREAS; SUPERIOR SENTENDE TO COSED HEAD INJURY	IR ME -
	a MASSIVE UPPER GASTROINTESTINAL	BLEEDING
rt II. Other significant cond	itions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dld tobacco us

Pe

3-24-98

e contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24b. Wera autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy

1 ☐ Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? examiner/ 1 Yes 2 □ No

1 npatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of 28a. Date of injury (Month, Day Year) 28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred PEDISTRIAN STRUCK BY AUTO

5 Pending invastigation Accident 6 Could not be determined 4 Homicide

28e. Piaca of injury - At home, ferm, street, fectory, office building, etc. (Specify)

11:00 AM

281. Location (Street and Number or Rural Route Nymber, City or Town, State) MARYLAND
LAUREL BOWIE POAD, LAUREL

29e. Certifier (Check only one)

27. Manner of Deeth

1 Neturel

PARKING LOT Certifying Physicten: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as steted.

Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier

29c. License number D23927

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year) APRIL 7,1998

30. Nema and eddress of person who completed cause of death (Item 23e) (Type, Print) VINCENT O. CASIBANG, M.D. 9410

Dang MD

ANNAPOLIS RD. #307 LANHAM, MD. 20706

Registrar

31. Dete filed (Month, Day, Year) APR 08



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	of De	ath		Reg. No.	12	708
	1. Decedant's I	Nama (First, Midd	dla, Last)							2. Data of Da Month	ath Day	Yaar	3. Tima of Death
Physician /Medical	Anna	L. Deg	ges							April	7, 1998		10:10 am
Examiner	4a Facility Nar	na (If not institution	on, giva st	treet and numb	oar)			4b. Ci	ity, Town, or	Location of Death	4c. County	of Death	
	5908 8	35th Ave	nue							ollton	Prince	e Geor	0
Funeral Director	5. Social Secur 578-24-	-3649	6. Sax 1 □	M 2⊠ F	Aga (in yrs. 85	last birthday) Yrs.	if Under Months		Undar 24 Hrs ours Min.	(Month, Da	th y, Year) 3, 1913	9. Birthpiac Country, Virgi	a (Stata or Forai) .nia
natural, or tems 23s or 28s-1 show alread Erroring and Erroring and Erroring and Erroring and Erroring and Erroring Director	Usual Rasidano	to of Decedant	· ·		10c Cit	y, Town or Lo	cation					104	Insida City Limit
sho of a			•									100.	1 Vas 2□N
or 28a-fa	Maryla	nd Princ	e Ge	orge s	Mou	nt Rair		0-4-			10g. Citizan of V	Affin at Country	
23a or 2 unit ben ral Dir		ueens Ch	napel	Road			10f. Zip	12			U.S.A		
"natural", or items 23s or 28s-1 show solical Exercises must be northed at leted by Funeral Director	3 ☒ Widow	lus Marriad 2□ Ma ed 4□ Divorce	rried	2. Was Decedo Armed Forc 1 ☐ Yas 2 If Yas, Give Yaar or Data	as? XI No			ant of Hispar ify Cuban, Ma ⊠ No Sp		Specify Yas or No to Rican, atc.)	Specify	e - Amarican ck, White, atc	
ygiene. Nor than "natura It, Ire Woulcal Completed	Elementary/	15. Deceda Specify only high Secondary (0-12)	ast grada	ation complated) Collega (1-4	or 5+)	(Giva life. L	kind of wor DO NOT us	l Occupation k dona during a ratired)	g most of wo	nking	16b. Kind of Bu		stry
Cor th	11					Hom	emake				Own Ho		
S SET		ma (First, Middla	, Last)					18.	Mother's Na	ma (First, Middla,	, Meidan Suman	na)	
	Willia	m Hardy	y Ja	cob G	rim			E	sther	Virgin	ia Grul	obs	
and se m	19a. Informant	's Name/Ralation	ship (Typ	e, Print)						ural Route Numb			
	James	Degges -	- Son						1 Road	l, Cotta	-		
of Heel	20a. Mathod of	Disposition 2 Cramation	2 DD	amount from St	20b. F	Place of Dispo cematary, cran	sition (Nem natory or of	a of har place)		Data	20c. Location -	City or Town	, Stata
int: H		ion 5 Othar (intoval front St		ington	Nati	onal C	emetery	4/13/98	Arlingt	on, Vi	irginia
Department of Heel Important: If Item 2 any injury or other office.	21. Signatura	of Funaral Sarvice	Licansa	a		Ga	sch's	Addrass of Funer	cal Ho	me nue, Hya	**	- 1/0	20781
nysician Medical xaminer	Immediata Car disaasa or con resulting in dec	dition	e.		CARCI	NOMA O	1000	PHAGUS	5			ino	tarval Batwaan nset and Death
as the buriel-transit	Sequantially list if any, laading cause. Enter L Causa (Disaas that Initiated av	a or injury	b . c.			or as a conseq		<u>.</u>					
use use	rasulting in das		L d.		Dua to (c	r as a conseq	uance of):						
by the atte	Part II. Other s	ignificant condit	ions cont	ributing to deat	th but not ras	ulting In tha u	ndarlying ca	ausa givan In	Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of dea
signed by the d be deteched by the d by the deteched by the deteched by by the did by by the sign of the deteched by by the sign of the deteched by the sign of the sign of the deteched by the sign of the sign o										10	Yes 2□ No	3 Probat	bly 4 Unkn
sete has been signage 2 should b										24a. Was	an autopsy ormad?	availa	autopsy finding abla prior to plation of causa ath?
page page										1 🗆	Yas 20 No	1 🗆 Y	as 2□ No
certificate rector, pag	25. Was casa	rafarrad to medic	al					26.	Place of De	eath (Check only	ona)		
		2 No	Ho	ospital:	patiant 2	ER/Outpatier	nt 3 DO	A Othar:	□ Nursing	Homa 5 Pasi	dence 8 □Oth	ner (Specify)	
Affer ti funera lon:		Daath 5 ☐ Pend	ing tigation	28a. Deta of (Month,		28b. Time of Injury		Bc. Injury at Work?	2 🗆 No	T	how injury occur		
after death. Director: After d in by the fune	2 Accida 3 Suicida 4 Homic	a 6 Could		28a. Plece of building	Injury - At h	oma, farm, str	reat, factory	, office		28f. Location (City or To	Street and Numb wn, Stata)	ber or Rural F	Routa Number,
s afte		1 Certifyi	ing Physi i Examin	er: On tha bas	ast of my kno is of axamina r stated.	wladga, daeth ition and/or inv	n occurred a vastigation,	at tha tima, d in my opinio	ata and plac n, death occ	e, and due to tha curred at tha time,	causa(s) and madata and place,	anner es stete and dua to th	ed. na causa(s)
s Funeral Dir letely filled in idical Cert	29a. Cartifiar (Check only one)	y 2 ☐ Medica		and mainta									
within 24 hours after for the Funerel Director Completely filled in IMedical Cert		2 ☐ Medica	ar	ano manna			29c	. Licansa nui	mbar		29d. Data signe	d (Month, Da	y, Year)
in 24 hounts Funer pletely fill edical	29b. Signatura	and titla of certifi	C /	J.	fon	MED		. Licansa nui D25165			29d. Data signe		
within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29b. Signatura		n who con	July Inpleted cause	-		Print)	D25165	5	shingtor	April '		

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 0.0

Physic	ian	1. Decedent's Nam	ne (First, Middle, Li Clarence	ast)	Day	enport	outo	of Death	2. Dete of De Month	Day	Yeer	3. Time of Deeth
/Med	ical			ve street end number		enforc		4b. City, Town, or	April		998 y of Deeth	7:15 am
Exam	ner	6701 Ric		ve street end number	7			Sykesvi		Carr		
Funera Director	_	5. Sociel Security N 579–42–21		Sex 7. A 1 XM 2 □ F	ge (In yrs. lest 88		Under 1 Y	ear If Under 24 Hr. eys Hours Mir		th ey, Year) 1909	9. Birthe Cour Utah	olece (State or Foreign htry)
the Maryland 28a-f show	tor	Usual Residence of 10e. Stete Md	f Decedent 10b. County Carroll			own or Location					,	0d. Inside City Limits 1 ☐ Yes 2 📉 No
ith with the Maryla 23a or 28a-f show	Funeral Director	10e. Street end Nu 6701 Ri	mber .dge Road			1	of. Zip Co. 2178			10g. Citizen of USA	Whet Cour	ntry?
ter dea	b	11. Marital Status 1 Never Marital 3 Widowed	ried 2 Married	12. Wes Decedent Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	1943)— ₁ ,	Decedent s, specify Yes 25	of Hispenic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)		ce - Americ eck, White,	etc.
d within 72 hours giena. r than "naturaf",	Completed	(Spec	15. Decedent's E	ducation rede completed) College (1-4or		6e. Decedent' (Give kind life. DO I	s Usuel Od of work de VOT use re	ccupetion one during most of we stired)	orking	16b. Kind of E	Business/In	dustry
be filed with that Hygiens and other the	Be Com	9 17. Father's Name			34)	Mili	tary	Service 18. Mother's Na	ame (First, Middle	U.S.		
should nd Men marke	ToB	Ratio		Davenport (Type, Print)		19b. Mailing A	ddress (St	Carr	ie Emily Rurel Route Numb	Prothe	ero n, Stete, Zip	Code)
Heal Heal		20e. Method of Dis 1 DBurial 2	position	Permovel from State	20b. Plece	6701 R e of Dispositio etery, cremeto ar Hill	n (Neme or ry or other	Road Syke	esville, Dete 4/11/98	MD 2178 20c. Location Washin	- City or To	
parmit. Pagas Department of Important: If it any injury or once.		21. Signeture of Fu			-2-	22. Na Ha	me end A	ddress of Fecility Funeral H ille, MD 2	Iome & Ch	apel (P	.O. E	
Physician				nolications that cause y one cause on each	ed the deeth. I	Oo not enter th	e mode of	dying, such es cerdia	ac or respiretory e	errest,		Approximete Intervel Between Onset end Death
/Medical Examiner	_	Immediate Cause disease or condition resulting in death)	(Final on	e. //Q	Due to (or es	anc e consequen		adder (A			1991- pres
certificate be axecuted anding physician and use as the burial-transit	n/Medical Examiner	Sequentielly list co if eny, leading to in ceuse. Enter Unde Ceuse (Disease or thet initiated event: resulting in death)	onditions, nmediate orlying Injury S Lest	6. H	TN	e consequence	e of):					
requires that the death cert een signed by the attending hould be detached for use a	Physician/N	Pert II. Other signif	licant conditions	contributing to death I	but not resultin	g in the under	lying ceus	e given In Pert I.	23b. Did	tobacco use co		o the cause of death?
2 s s	Completed by								24a. Wes	s en eutopsy ormed?	ev	ere eutopsy findings elleble prior to impletion of cause deeth?
VITAL H	0	25. Was case refer	red to medical					26. Place of De	1 aath (Check only	/	1(Yes No
- S 0	To B	exeminer?	/	Hospitel: 1 Inpati	ient 2□ER	/Outpetient 3	DOA	Other: 4 Nursing	. ,	idence 6 □Ot	ther (Specia	(y)
ing ing	ertification:	27. Manner of Deel 1 Haturel 2 Accident	5 Pending Investigation		ury ey Year) 28	b. Time of Injury		Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occu	irred	
DIVISION all or Attending s after death. if Director: After ad in by the fune	Certific	3 Suicide 4 Homlcide	6 Could not be determined	286. Place of In	njury - At home tc. <i>(Specify)</i>	, ferm, street,	factory, of	fice	28f. Location City or To	(Street end Num wn, Stete)	ber or Rura	al Route Number,

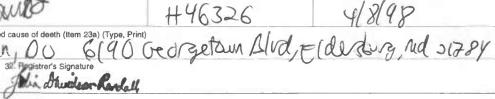
29a. Certifier

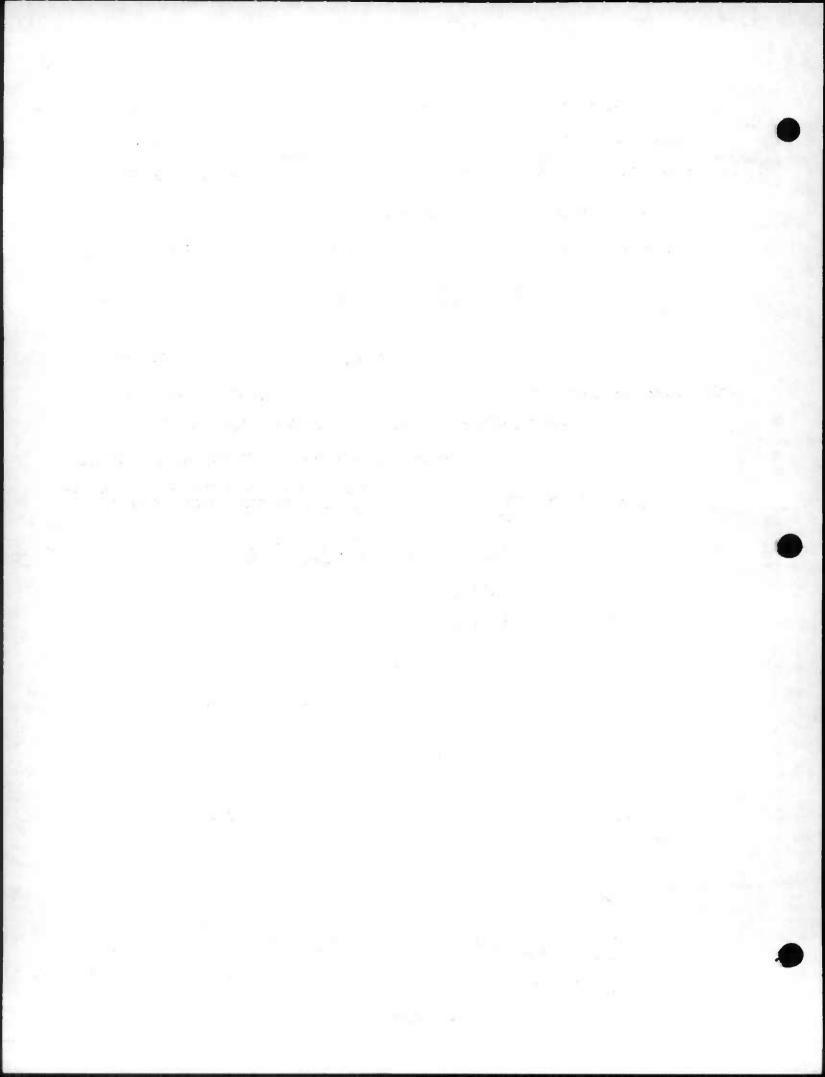
dertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner stated.

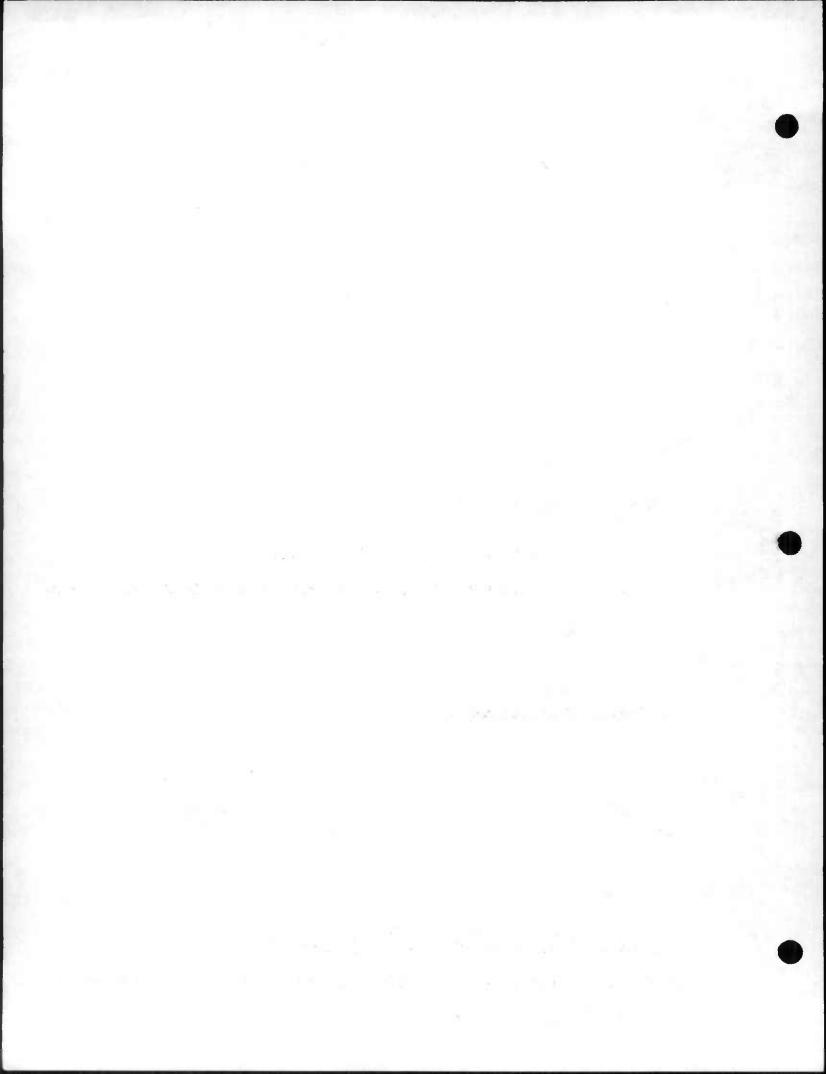
29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Day, Yeer)





_					State of Ma	arylana /	Certificat			Wichtan	Reg. No	98	12710
П	Physic	lan	Decedent's Neme (First, M.							2. Dete of D Month	De		3. Time of Deeth
J.	/Medi	cal	Mervin Euge							Apr		, 1998	12:55 pm
и	Exami	ner	4e. Fecility Neme (If not instit						4b. City, Town, or		oth 4c	c. County of Deet	
H		_	Lookabout C 5. Sociel Security Number	are E		e (In yrs. last bi	rthday) If Under	1 Yeer	Westmin If Under 24 Hrs		itali.		rroll
	Funeral Director		217-01-7217 Usuel Residence of Deceder	1	M 2□ F	89	Yrs. Months	Deys	Hours Min				hplece (Stete or Foreign buntry) PA
	dand ow		10e. State 10b. Co			10c. City, Tow	n or Location						10d. Inside City Limits
	Mary Fred	to	MD Car	roll		Westmi	nster						1 ☐ Yes 2 1 No
	h with the 23a or 28a	ai Director	10e. Street end Number 534 Unionto	wn Ro	oad		10f. Zip	Code	211	58	10g. Ci	itizen of Whet Co Unit	ountry? ced States
020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any follury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Maritel Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Divo		12. Wes Decedent to Armed Forces? 1 ☐ Yes 2 12 N If Yes, Give Year or Dates:	Ever in U,S.	13. Was Dece If Yes, spe 1 \(\subseteq Yes		dispenic Orlgin? (Sen, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	10-	14. Race - Ame Black, White Specify:	e, etc.
21215-0020	2 hou	ba		dent's Ed		16e	. Decedent's Usu	el Occur	petion		16b. K	(Ind of Business/	White
215	nin 72	Completed	(Specify only hi Elementary/Secondery (0-	ghest gre	de completed) College (1-4or 5		(Give kind of wo	rk done se retire	during most of wo	orking	1001		
21	d with	E O	12	2)	College (1-4015	+)	Steam Fi	tte	r			Uni	.on
nd	el Hy othy	Be	17. Fether's Neme (First, Mic	dle, Last)					18. Mother's Na	me (First, Midd	le, Meider	n Sumeme)	
yla	Ments Ments arksd	To	Clayton R.	Dear	dorff					Sall	v.C.	Koontz	
Maryland	2 sho and is me		19e. Informent's Name/Relat	onship (7	Type, Print)	198			end Number or R	ural Route Num	ber, City	or Town, Stete, 2	
	end ealth 7 27		Thomas E. D	eardo	orff, son				d Ridge	Drive,	7		MD 21158
Baltimore,	Peges 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 M Burial 2 ☐ Cremet 4 ☐ Donetion 5 ☐ Othe			cemete	of Disposition (Ner ary, cremetory or c eadow Bra	ther ple	ce) 04/ Cemeter	07/98 Y		ocation - City or estminst	
Ball	permit. Depart Import any in		21. Signature of Funeral Sen	ice Licen	300 Pai H = - As	#i#	22. Name ar Prit 412	d Addre	Funeral i	Home & Rd., We	Chape	el nster, M	ID 21157
	Physician /Medical Examiner	er	23a. Part1. Enter the disease shock, or heert feilure. Immediate Ceuse (Finel disease or condition resulting in death)	, or comp List only	e. RESPI	RATO Due to (or es e	consequence of):	-A1	LUPE				Approximete Intervel Between Onset end Deeth
Box 68760,	sath certificete be executed ettending physician and for use es the buriel-transit	n/Medicai Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest	{	c	Due to (or es e	consequence of):	IVE	PULNO	water	DIS	SBASE	YEARS
œ.	death e ette id for	icia	Pert II. Other significent con	ditions co	entributing to death bu	ut not resulting l	n the underlying o	euse niv	ven in Pert I	23h Die	d tobacco	n uee contribute	to the cause of death?
s, P.O.	ires that the death cer signed by the ettendin id be detached for use	by Physician/M	ATRIAL	-	Beilla		in the dildenying c	ouse gre					robably 4 TUnknown
Record	aw requisite been 2 should	Completed t								24a. We	s en euto formed?		Were eutopsy findings evailable prior to completion of cause of deeth?
		Con								1□	Yes 2	CINO	1 □ Yes 2 □ No
ita	ician: The certificate rector, pag	Be	25. Wes cese referred to med exeminer?	lical					26. Place of De	eth (Check only	one)		
>	nysio lis ce	ို	1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpetient 3 DC	A Oth	er: 4 \subseteq Nursing I	lome 5 Re	sidence	6 □Other (Spe	cify)
Division of Vital	or Attending Physician: after death. Director: After this certifical in by the funeral director,		E LI MODIO OTT	estigation			Time of 2 Injury M	8c. Injur Wor 1 🗆	y et k? Yes 2 □ No	28d. Describe	how inju	iry occurred	
Divis	al or Attendes safter deati	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	uld not be ermined	28e. Plece of Inju- building, etc		erm, street, factor	, office		28f. Location City or To	(Street ei own, Stete	nd Number or Ru e)	ural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai (e, end due to the urred et the time	e ceuse(s e, dete en	s) end menner es d plece, end due	steted. fo the ceuse(s)
	To the To the comple	M	29b. Signature end title of cer	2	and -	PHYSIC	CAN		UISS		29d. De	ete signed (Mont	h, Day, Yeer)
			30. Name and eddress of per ARTHUR L 31. Dete filed (Month, Day, Y.)	Re	CP,000			707	IRD L	~ E37	T2W	ER, MD	21157
	Sta Registr		APR (Audien	ardall						



State of Maryland / Department of Health and Mental Hygiene Q

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	1			П
- 1	6-	- 1	a.	- 8

					Cei	rtificat	e of	Death		F	Reg. No.	, 1	C/11
	1. Decedent'e Name	(First, Middle, La	ist)							2. Dete of Dee		Year	3. Time of Death
Physician	MARGELIN	0 D. E	MRALINO								B, 1998	}	7:52 P.M.
/Medical Examiner	An English Name ///	not institution, giv	ve street and num	nber)				4b. City, To	wn, or Lo	cation of Deeth	4c. Count	y of Deeth	
	3702 65T	H AVENUE	2					HYATT		and the same of th		ICE G	EORGE 'S
Funeral	5. Sociel Security Nu	mber 6. S	Sex 1MM 2□F	7. Age (In yrs. las		If Under Months	1 Year Deys		24 Hrs. Min.	8. Date of Birt (Month, De)	, Year)	9. Birth	place (State or Foreign intry)
Director	352-42-44 Usuel Residence of D	90	IM ZUF	76	Yrs.					JAN. 3,			IPPINES
ylan how		10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
Iter death with the Maryland ritems 23s or 28s-f show ther must be notified at	MARYLAND	PRINCE	GEORGE'S	HY	ATTS	/ILLE							1 ☐ Yes 2 ☐ No
er th	10e. Street and Num	ber				10f. Zip	Code				10g. Citizen of	Whet Cou	intry?
th with with unit be real Disc	3702 65TH	AVENUE				20	0784	+			UNITE	STA'	TES
tar daa Items	11. Marital Stetus		12. Wes Dece Armed For	dent Ever in U,S. ces?	13.	Was Deced	dent of cify Cul	Hispanic Or pan, Mexica	igin? (Spen, Puerto	cify Yes or No- Rican, etc.)		ice - Ameri eck, White	ican Indien, , etc.
0 0 0	3 ☐ Widowed 4		1 Tes If Yes, Give Year or De	9		1 🗆 Yes	2 X] No	Specify.	:		Speci	ily: FILI	IPINO
Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiana. Important: If Itam 27 is marked other than "natural", or any injury or other traumatic event, trailed and price.	(Specif	15. Decedent's E y only highest gr	ede completed)		(Give	dent's Usu kind of wo DO NOT u	rk done	during mos	st of worki	ing	16b. Kind of	Business/Ir	ndustry
212 I with iana. than	Elementery/Secon	dery (0-12)	College (1-	-40r 5+)	ATTO	DRNEY					CITY (GOVER	NMENT
and the state of t		First, Middle, Last						18. Moth	er's Neme	(First, Middle,	Maiden Sume	me)	
Viar Wenta Wenta wrked write ev		EMRALING)					AGA	TONA	DUFALE			
Maryiand d 2 should be file th and Mental Hy 7 is merked oth traumatic event	19a. Informent's Nar	me/Reletionship	(Type, Print)		19b. Maili	ng Address	(Stree	t end Numb	er or Rura	il Route Numbe	r, City or Tow	n, Stete, Zi	ip Code)
Mind 2	PILAR EM	RALINO,	WIFE		3702	65TH	AVE	ENUE,	HYAT'	TSVILLE	, MARYI	LAND	20784
Itam Itam othe	20e. Method of Dispo	osition	1 - 21	Can	ca of Dispo	osition (Nei	me of			Dete	20c. Location		own, Stete
Baltimore, semit. Pagas 1 al separtment of Hac mportant: If Item more in the land.		Cremetion 3 L 5 ☐ Other (Speci	Removel from S	State		COLN			1	4/14/98	BRENT	VOOD,	MARYLAND
Balt Departiment.	21. Signeture of Fun	erei Service Lice	1300 A	. 1 . 6				ess of Facili		L HOME			
W 40189	1 Da	SA V	. XAM	NOW	U 34	401 BI	LADE	ENSBUR	G RD	., BREN	TWOOD,	MARY	LAND 20722
	23a. Pert1. Enter the shock, or heart	e diseese, or con failure. List only	plications that ca	aused the deeth.	Do not en	ter the mod	de of dy	ing, such es	cardiac o	or respiretory en	rest,		Approximete Intervel Between
Physician												1	Onset end Deeth
/Medical Examiner	Immediete Ceuse (F disease or condition		. PULMOI	NARY FAI	LURE							1	2 MONTHS
	resulting in deeth)			Due to (or e	111	quence of)							
B 5			b METAST	TATIC CA	NCER								8 MONTHS
axecuted an and rial-transit	Sequentially list conditions if any leading to imp	ditions,		Due to (or e	s e conse	quenca of):						1	
60, be axecul ician and burial-trar	if eny, leading to immore cause. Enter Underlocuse (Disease or in thet Initieted events	ying njury	c. CANCE	R OF LUN	G								
68760, ficate be assouted physician and is the burial-transit	thet initiated events resulting in deeth) Le	est		Due to (or e	s e consec	quence of):						i	
Die N	Ε	-	d									1	
	5									1			
O. tha dy tha ached	Part II. Other signific	eant conditions	contributing to de	eth but not result	ing in the u	inderlying o	ause g	iven in Pert	I.				to the cause of death?
										10	Yes 2∐ No	3 Pro	obably 4X Unknown
Records, ha law requires th a has been signed aga 2 should be dominated by										24e. Wes	en eutopsy	24b. V	Vere autopsy findings
The law require cate has been single and 2 should Completed	8									perfo	med?	0	veileble prior to completion of cause
0 8 8 0													deeth?
al R		"								10		1	☐ Yes 2 X No
of Vital Re Physician: Tha le this cardificate he ral director, page	25. Wes case referre		Hospitel:				. 0	thor:		h (Check only o			
O f 5 7		10			R/Outpatie 8b. Time o		Un	4 🗆 14	-	me 5 K Residente 1			ary)
Attending Ph ir daath. ector: After th by the funeral	1 XNeturel	5 Pending investigation		of Injury h, Dey Year)	Injury	М	28c. Inji W	ork? ⊒Yes 2□					
Vision Attending in death. •ctor: After by the funs	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b	e 28e. Pieca	of Injury - At hom	e, ferm, st					28f. Location (Street and Nur	nber or Ru	ral Route Number,
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DHMH 16 Rev 6/95

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Physicia /Medica Examine

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours effer death with the Manyland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show sylighty or other treumstic event, the Modical Evant her must be notified at once.

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0020

ANTHONY FREEMAN

		Ce	rtificate	e of i	Death			Reg	. No. 9		6113
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Anthony W	ayne Freem	an					APRIL			1998	4:40A.
e Fecility Neme (If not institution, give	re street end number)			4	b. City, To	wn, or L	ocation of De	ath	4c. Count	y of Death	
PRINCE GEORGES HO	SPITAL				CHEVE				PRINC	CE GE	ORGES
	Sax 7. Aga (In yrs.	lest birthdey)	If Under Months	1 Year Devs	If Undar Hours	24 Hrs. Min.	6. Date of E	Birth Dev. Y	ear)	9. Birth	plece (State or I
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0e. State 10b. County	10c. Ci	ity, Town or Lo	ocation								10d. Inside City
Maryland Prince	George's			Bla	densb	ourg					Yas 2
0e. Street and Number			10f. Zip	Code				100	. Citizen of	Whet Cou	intry?
5716 Emerson St	reet. #135				20710					£7(7) 3	
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3 Widowed 4 Divorced	If Yes, Give Year or Datas:		1 ☐ Yes 2	2₩ No	Specify:				Speci	b: B1	ack
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Elementary/Secondery (0-12)	College (1-4or 5+)										
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7. Fether's Nama (First, Middle, Last					18. Mothe	ers Nem	e (First, Midd	ie, Ma	iden Suma	ma)	
David Martin						Mar	y Free	mai	1		
9e. Informent's Neme/Reletionship (Type, Print)	19b. Maili	ing Address	(Street	end Numbe	er or Au	rel Route Nun	ber, (City or Town	n, Stete, Z	ip Code)
David Martin/Fa	ther	5716	Emer	cson	Stre	et #	135. F	R1ac	denshi	1r: / .	MD 2071
Oa. Method of Disposition	20b. I	Place of Disponentery, cre	osition (Nem	ne of	-1		Data	20	c. Location	- City or T	Town, State
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O.C.M.E.

APRIL 5,1998

111 Penn Street, Baltimore, Maryland 21201

State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burnel-transit

Division of Vital Records, P.O. Box 68760,

31. Dete filed (Month, Day, Year)

of person who completed cause of deeth (Item 23a) (Type, Print)

APR 08 1996

32. Registrer's Signeture

BALTIMORE, MARYLAND 21215-0020

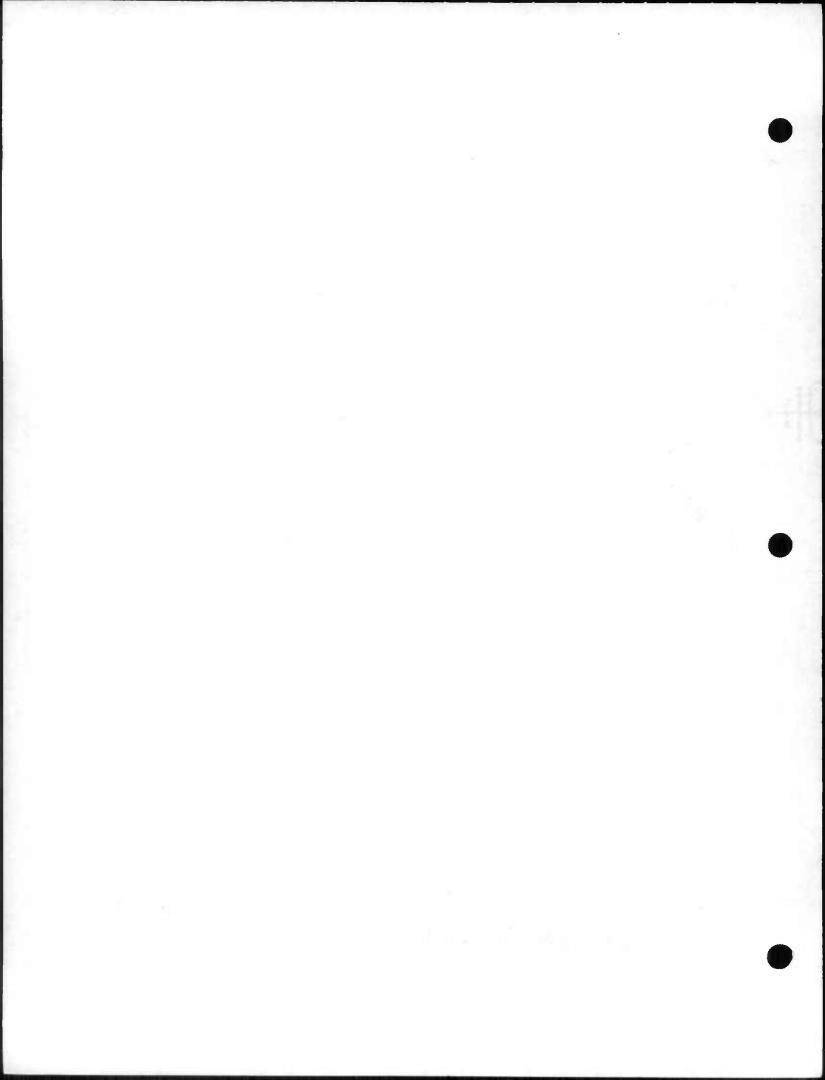
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

* REGISTRAR 1. DECEDENT'S NAME (First	t, Middle, Last)				0, (, ,	OF D		1	2. DATE OF DE	G. NO.		3. TIME OF DEATH
Bonnie J.	Emio								MONTH Amari 1	DAY 7	1998	
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. In:		IF UNDER		UNDER 2	4 HRS.	7. DATE OF BI	DTH	e DID	THPLACE (State or Foreign
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10e. STREET AND NUMBER						101. 71	P CODE			100	CITIZEN OF	1 VES 2 NO
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Never Married 2			MAR OR DATES	NO		If yes, specif	y Cuban	, Mexican Specify:	, Pusrto Rican,	atc.)	B4	eck, White, etc.
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7	41.00		1 11	ousew	OLIC			10.0				
7. FATHER'S NAME (First, M Washingto		Ford				11			ME (First, Middle,	, Maiden Surna	me)	
190. INFORMANT'S NAME (.014	140	N. MAH ING	100000	2 (2)		_	Green oute Number, Ch			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	i
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	S. Gre	en			2. DATE OF DEATH MONTH	AY Y	YEAR OL! 55 A M	
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)		NDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign	
	579-54-7460	1 □ M 2,□XF	76 YRS.	ONTHS DAYS HOU	RS MIN.	NOV. 06,	1921	Virginia	
-	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN								
DIRECTOR	Pineview Nursing Home Clinton Prince George's								
EC	10a. STATE 10b. COUNTY 10c. CITY, TOWN (OR LOCATION			10d. INSIDE CITY	
DE	Maryland Prince George's			Temple	5		LIMITS?		
.AL	10e. STREET AND NUMBER			10f. ZIP (10g. CITIZE	N OF WHAT COUNTRY?		
ETED BY FUNERAL	2011 Iverson Street				20748			USA	
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2- NO IF YES, GIVE WAR OR DATES		13. WAS DECENDED If yes, specify 0 1 YES 2	Cuben, Mexic	NIC ORIGIN? (Specify Year, Puerto Rican, etc.) fy:	INP (Specify Yee or No— b Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: Black		
	18. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S US (Give kind of wor			WAL OCCUPATION	AL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY fored buring most of working fired.)				
Ē	Elementary/Secondary (0-12)	Condary (0-12) Conege (1-4 or 5 +)							
COMPL	17. FATHER'S NAME (First, Middle, Last)	4+ Registered Nurse				Government			
	Rawlins James Shepperson			18. 8	18. MOTHER'S NAME (First, Middle, Maiden Surname)				
BE				DRESS (Street and Nu	Hester Keeling RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
2	Robert F. Green III/Son 3418 Curtis Drive #604, Hillcrest Heights, M								
	20e. METHOD OF DISPOSITION	20b.		DISPOSITION (Name of		DATE 20c. LC	CATION - CIT	y or Town, State	
	1 Donation 5 Other (Specify)	Come	ams Memori	ial Pk	4/11 Roa	noke,	Virginia		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J. B. JENKINS FUNERAL HOME								
	Nancy A Percente 7474 Landover Road, Landover, MD 20785								
	23. PART i. Enter the diseases, or abook, or heart fellure.	complications that caused List only one cause on ea	the death. Do not	enter the mode of	dying, aud	ch as cardiec or resp	iratory arrea	t, Approximata	
	IMMEDIATE CAUSE (Finel							Interval Between Onset and Death	
CERTIFICATION	disease or condition resulting in death)	· Mysca	CONSEQUENCE OF):	enfa	rein	on		Gudden	
	Sequentially list conditions, Majoral Canadial infarction								
	Sequentially list conditions, if any, leading to immediate	jipe og	nge meny agreem						
3	cause. Enter UNDERLYING CAUSE (Disease or Injury								
I E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST								
1 15	d								
AL C	PART II. Other aignificant condition		t not reaulting in	the underlying caus	se given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
	Blindnes	a			PERFORMED? 1 YES 2 NO COMPLETION OF COMPLET				
MEDIC								1 TES 2 NO	
ä									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:								
HYS	1 YES 2 NO	1 Inpatient 2 ER/Outpa	28b. TIME (Nursing Home 5			N HIM OCCU	000	
	1 Natural 5 Pending	(Month, Day, Year)	INJUR	Y WORK?		28d. DESCRIBE HOW	NJURY OCCU	ÆU	
р ву	2 Accident Investigation 3 Suicide 8 Could not be	Accident Investigation Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street,			, factory, office 281.		1. LOCATION (Street and Number or Rural Route Number,		
1	4 Homicide determined building, stc. (Specify)								
COMPLETED	29e. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(e) and manner as stated.								
OM	one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.								
ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER 29d. DATE SIGNI			IGNED (Month, Day, Year)	
TO B	Hun le le ortho.			7	D15595 104/04/98				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) HYO K. LEE, 14D, 11610 LOCUST GLEN DR 191 TCHELLVILLE NO								
	31. DATE FILED (Month, Day, Year) APR 08 1868 32. SEGISTRAR'S SIGNATURE 20724								

APR DB 1888 Shi Malandaha

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey Year **Physician** Letitia Rose Giese 1998 April 12:35 am 6, /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 10108 Logan Drive Potomac Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1□M 2\ F Months Yrs. 79 Director 544-07-2382 July 13, 1918 Oregon Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified as 1 Yes 2 No Directo Maryland Orange Mission Viejo 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? with 23565 Ribalta 92692 2 should be filed within 72 hours after death vand Mental Hygiena. Is marked other than "netural", or Items 23. Funeral U.S.A. 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Maritel Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joe Elliott Letitia May Gilmore permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alfred E. Giese - Husband 23565 Ribalta, Mission Viejo, California 92692 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 🖾 Removal from State 4 □ Donation 5 □ Other (Specify) Fairhaven Memorial Park 4/11/98 Santa Ana, California Signature of Fune 22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD.
Do not enter the mode of dying, such as cardiac or respiratory arrest, 20781 Approximete interval Between Onset and Death for the disease, or complications that caused be heart failure. List only one cause on each in a **Physician** IN FARCTION /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner ARNO VASCULAR DI Examiner ARTERIO SCLEROFIC attending physician and for use as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of) 88 nse nse The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PRACTURED þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed been s completion of cause of death? has 1 Yes 21 No 1 ☐ Yes 2 ☐ No certificate Division of Vital i or Attending Physician: after death. Director: After this certifica 25. Was cese referred to medicel examiner?
11/21 ¥es 2 □ No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatlent 3 DOA After this c 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined n 24 hours after des Ne Funerel Director pletaly filled in by the 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetien and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical npletaly (Check only Within 2. To the 29b. Signature and title of cad 29c. License number 29d. Date signed (Month, Dev. Year) D07099 April 7, 1998

State Registrar

APR 08 1998 Set Swill

Francis C. Mayle, M.D.

31. Dete filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

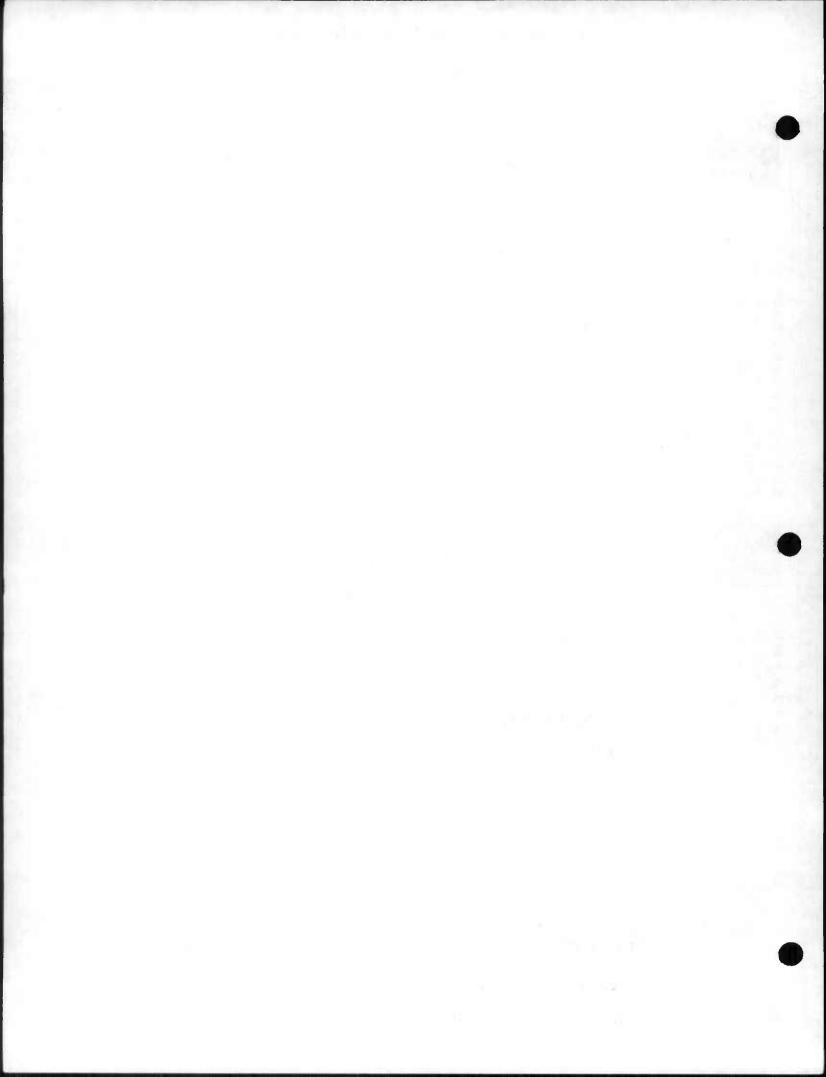
10215 Fernwood Road, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Von **Physician** NATALLE MARGARET GOODIS 1998 APRIL 0410 6 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Copper Ridge Sykesville Carroll If Undar 1 Yaar If Undar 24 Hrs.
Months Deys Hours Min. 7. Aga (In yrs. last birthday) 5. Social Security Numbar Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months 1□ M 2 F Yrs. Director 120-14-0158 87 Oct. 9, 1910 New York Usual Rasidence of Dacadani the Meryland 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumetic event, the Medical Examinar fruit to nouthed at 1 NY Yas 2 No Carroll Westminster Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 354 Doral Court 21158 United States death Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Dacadant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiane. Important: If Item 27 is merked other than "natural", or item any Injury or other traumatic event 1 Nevar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 1 No Specify: lf Yas, Giva Yaar or Datas: Specify þ 3 ☑ Widowad 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) worker United Airlines 10 17. Fether's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Sumame) Be 0 Cashimus Rembis Michaelina Culakoska 19a. Intormant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carole Fuss, daughter 354 Doral Court, Westminster, MD 21158 20b. Pleca of Disposition (Name of cematary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 04/08/98 1 Burial 2 □ Cramation 3 □ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Pipe Creek Cemetery Uniontown, MD 21. Signatura of Funaral Sarvice Licansee 22. Periate and Address of Facility Home & Chapel 412 Washington Rd., Westminster, MD 21157 23a. Part1. Entar tha diseesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory errest, shook, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Death Physician /Medicai Immadiata Causa (Finel disaase or condition resulting in daath) CONGESTIVE HEART FAILURE Examiner Due to (or es a consequança ot): Physician/Medical Examiner AGRICA FIBRICIATION physician end the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or Injury that initiatad avants rasulting In daath) Last Due to (or as a consequence of): Box 68760. Dua to (or as a consequence of): 80 ettending 9SU 0 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. by the 23b. Dld tobacco use contribute to the cause of death? deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown HRTERY signed b Division of Vital Records, by 24a. Was an eutopsy performad? 24b. Wara autopsy tindings available prior to Completed peen Haptertonson completion of cause of death? Nes page 2 1 TYas 2 DNo 1 Yas 2 No certificate director Be 25. Was case raterred to madical examiner? 26. Placa ot Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatiant 3 DOA funerel 28a. Data of Injury (Month, Day Year) 27. Menner of Daath 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Aftert or Attanding 1 Natural 5 Panding invastigation within 24 hours efter death.

To the Funeral Director: Al completely filled in by the fu death. 1 Yas 2 No 2 ☐ Accident 6 Could not be datarmined 3 ☐ Suicide 28t. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, straat, tactory, offica building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Phyalcian: To tha bast of my knowladge, deeth occurred et the time, date end place, and dua to tha causa(s) and mannar es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signad (Month, Day, Year) acch 948189 APRIL 6 1998 trass of person who complated causa of daath (Itam 23a) (Type, Print) DR JACOB M. LEVINE 710 OBRECHT RD SYKOSUILLE 32. Registrar's Signatura 31. Data tiled (Month, Day, Year) State APR 08 1998 Registrar



1. Decodent's Name (First, Middle, Last) DAVID HOLMES, JR.		Item: 5 per F.H G-759			rtificate of	Death		Reg. No.		
### As Poulty Nerver (Prior installation, prior designed and number) ### As Poulty Nerver (Prior installation, prior designed and number) ### As Poulty Nerver (Prior installation, prior designed Designed) ### As Poulty Nerver (Prior installation, prior designed) ### As Poulty Nerver (Prior installation, prior designed) ### As Poulty Nerver (Prior installation) ### As Poulty Number ### A	ian						Month	eeth Day	Yeer	3. Time of Dea
Mariner of Southern Maryland 5 South Service Williams (1992) 10 South Proposition (1992) 10 Colly Trans of Location Washington 10 Loc Cly, Trans of Location 10 Loc Cly, Trans							April		8	4:10 P
Social Security Number 12	ner			229						1
The part of the part	М				Killeder 4 Vene					_
D. C. Washington 10, 72 Code 20020 10, Citzen of What Country 3413 Texas Avenue, S. E. 20020 11, Marinal Status 11, Marinal Status 11, Marinal Status 11, Marinal Status 12, Wash Deposited Fiver in U.S. 13, Wash Deposited Fiver in U.S. 14, Wash Deposited Fiver in U.S. 15, Depos		579-28-3708 700	- Af	7.4		Hours Min.	8. Date of Bi	8, 1926	9. Birthple Caunti Washi	ece (State or Fo. Lngton
Toe, Street and Number 100, Street and Numbe									10	d. Inside City Li
11. Marie Season 1.1. Marie Season 1.2. Was Decedent Ever in U.S. 1.2. Was Decedent of Hispanic Origin (Specify Yes or Note 1.2. Marie Season 1.2. Marie Sea	ctor	D.C.	W	ashing	ton					1 Yes 2□
11. Maries Balasus 12. December 12. De	Dire					2.0		10g. Citizen of	Whet Countr	ry?
Specific Park Cive Park	rai	3413 Texas Ave			2002	20		U.	S.A.	
David Holmes, Sr. 19. Malling Address (Street and Authority Property of Part II. Other algorithms of Contribute to the cause of the Part II. Other algorithms of Contributing in death but not resulting in the underlying cause given in Part I. 19. Malling Address (Street and Authority of Part II. Other algorithms of Contributing in death) 19. Malling Address (Street and Authority Property Contribution of Part II. Other algorithms of Contribution of Cont	by	1 ☐ Never Merried 2 Ă Married	If Yes, Give	U,S. 13. v			pecify Yes or No o Rican, etc.)		ck, White, et	tc.
Tester's Name (First, Middle, Lest) David Holmes, Sr.	ted	15. Decadent's E	Education	16e. Deced	lent's Usual Occu	pation	,	16b. Kind of B	usiness/îndu	ustry
Tester's Normal (First Middle, Last)	Comple		College (1-4or 5+)				king	Federa	l Go	vernme
David Holmes, Sr. Secondary Control Con						18. Mother's Nar	ne (First, Middle	, Maiden Sumar	ne)	
Sequentially list conditions and contributing to death but not resulting in the underlying cause given in Pert I. Due to (or es a consequence of):	To					Lotti	e Batt	le		
Constitution Cons		19a. informant's Name/Relationship Geneva G. Holm	(Type, Print) es/Wife	19b. Mailin 3413 Wash	ng Address (Street Texas ington,	ANENUE C	20 · E ·	per, City or Town	, State, Zip C	Code)
22. Name and Address of Facility. Henry S. Washington & So. O. Inc., 4925 N.H. Burroughs Ave., N. Washington & So. Onset and So. Onse		1 Buriel 2 □ Cramation 3 [Removel from Stete Ma	rylano	der Nather B	hal Cem	/14/98	Laurel	, Ma:	ryland
Due to (or es a consequence of): Sequentially list conditions, if early lightly lig		126	Taylor	Co Wa	Name and Address., Inc.	ess of Fecility He 4925 on DC 2	nry S. N.H. E	Washi Burroug	ngtor hs A	n & So ve., N
Immediate Cause (Final desease or condition resulting in death) Due to (or es a consequence of):		23a. Part 1. Enter title disease, or con shock, or heart feilure. List only	plications that caused the dea	ath Do not onte	ar the mode of dvi		as sandantes a	area ed	-	
Due to (or es a consequence of): Due to (or es a consequence of):			one cause on each line.	atii. Do not ente	or the mode of dy	ng, such es cardiac	or respiretory a	irrest,	1 (Approximate
Due to (or es a consequence of): Sequentially list conditions is law, leading to formadite cause. Enter Underlying cause (Disease or Injury hast infelied events resulting in death) Lest Due to (or es a consequence of):			one ause on each line.	atii. Do not ente	or the mode of dy.	ng, such es cardiac	or respiretory a	urest,	- 1	Approximate ntervel Between Onset end Deeth
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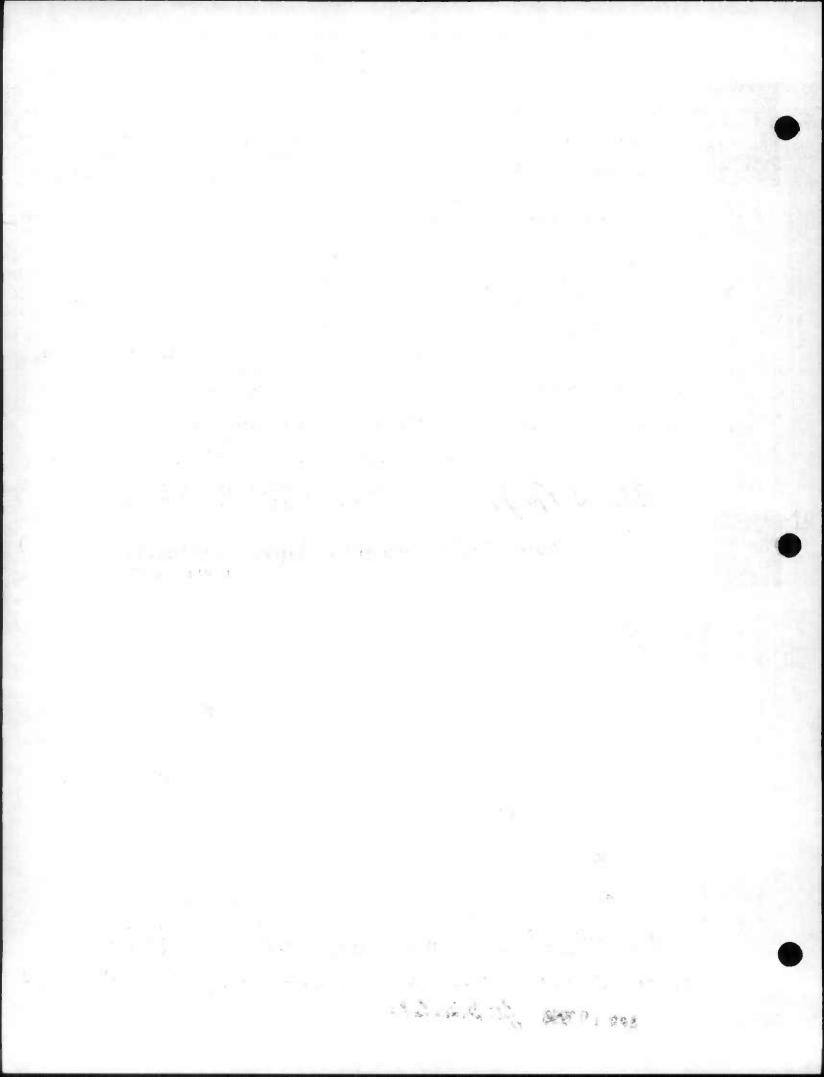


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	To the Hospital or within 24 hours afte To the Funeral Dir. completaly filled in	Medical C	29a. Certifier 1 Certify (Check only one) 1 Certify	ying Physicisn: To the ball Examiner: On the bes	is of exemine	wledge, deeth tion end/or Inv	occurred et the tir estigation, in my o	ne, dete end plece pinion, death occu	, end due to the rred et the time,	ceuse(s) end me date end place,	enner es stete end due to the	d. e ceuse(s)
	To the within To the comple	M	29b. Signatura and title of certi	jer				e number Md	,	29d. Dete signe	d (Month, Dey	r, Year)
			Jame &	Mass	>	M.D.	D3	4502		418	198	
			30. Name and address of personal RPUCE PSO	who completed cause	of deeth (Item	1221		antile	la.,	Lasgo	NJ.	20774
	Sta	ite	31. Data filad (Month, Day, Yee)r) 32 Per	gistrar's Signe	eture	,			7		

Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Veer **Physician** 1998 A. Gertrude Horstkamp April 10:00 am /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Greenbelt

If Under 24 Hrs.
Hours | Min.

Jan. 12, 19 Prince George's Greenbelt Rehabilitation Center ff Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** 1 M 2 F Months Deys Yrs. 1908 Washington, DC 577-10-0196 90 Director Usuel Residence of Decedent with the Maryland r 28a-f show 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Prince George's Maryland Bowie 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number an "naturel", or items 23s or Medical Examiner must be permit. Peges 1 end 2 should be filed within 72 hours efter death v Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23e ent hijury or other traumatic event, the Modical Examiner mans once. U.S.A. 8229 Triple Crown Road 20715 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) Private Industry 12 Bookkeeper 18. Mothar's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Mary Frances Mahorney 0 William Bernard Becker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8229 Triple Crown Road, Bowie, Maryland 20715 John J. Horstkamp, Sr. - Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete 20e. Method of Disposition Data 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4/7/98 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Sendce Licensee 22. Name and Address of Fecility Thompson Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part. Enter the dispase, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** /Medical Immediete Ceuse (Final tow Coronary Drga WESSE disease or condition resulting in deeth) Examiner Dua to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequence of): 80 for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown eripheral Variator Docar ģ sees of from the surface of a con 24b. Wara eutopsy findings availabla prior to completion of ceuse of deeth? 24e. Was en eutopsy performad? Completed nis certificate hes b 1 Yas 2 No 1 TYes 2 No or Attending Physician: Be 25. Was casa rafarrad to medical 28. Piece of Death (Check only ona) xeminer? Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Mannar of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 ☐ Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, and due to the ceuse(s) and menner es stated.

(Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, and due to the ceuse(s) and menner estated.

(Check only one) edicai 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of certifian no 102 ld-30. Neme and address of person who completed cause of death (Itam 23e) (Type, Print)

7404 Executive Place, #502, Seabrook, Maryland 20706

DHMH 16 Rev 6/95

State

Registrar

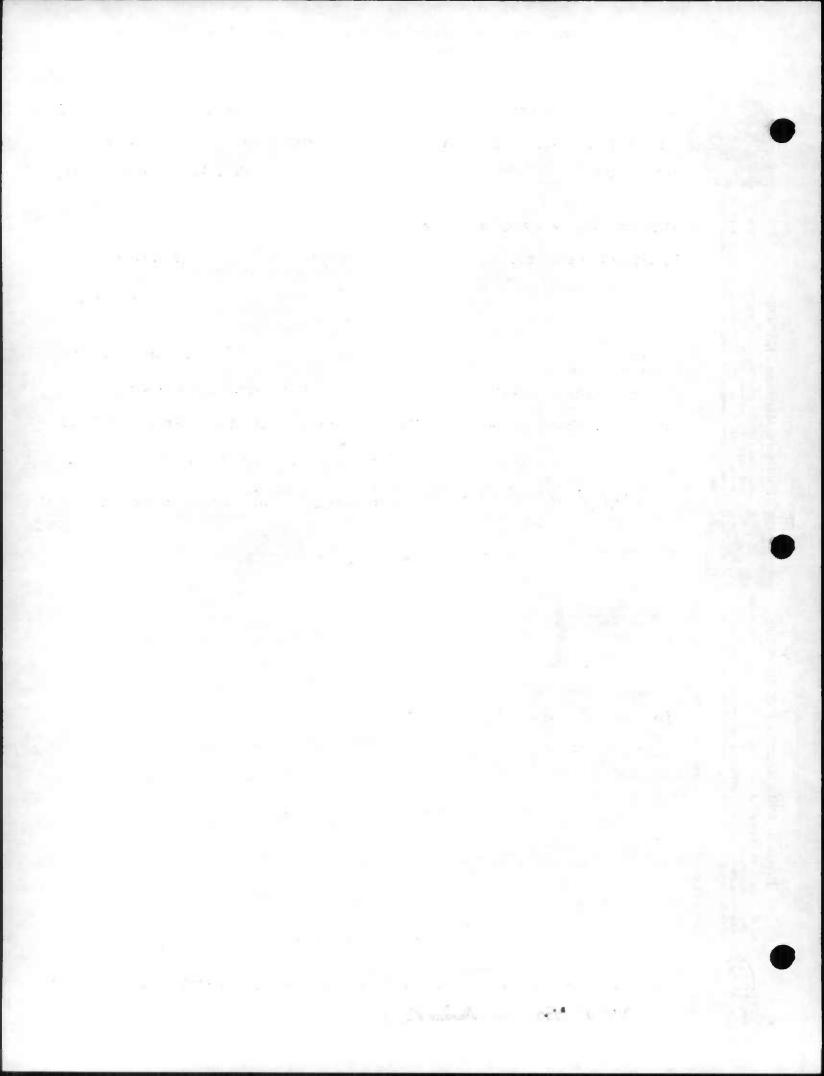
Don H. Yablonowitz, M.D.

APR 07 1998

32 Registrer's Signature

Jak Studen Rarlell

31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth APRIL **Physician** -ASSIE 2200 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** LORIAN NURSING HOME OF COLUMBIA MARYLAND COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year 9-28-1912 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 M Months Deys Hours 85 Georgia Director 253-30-0608 Usuel Residence of Decedent the Maryland 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, in Madical Examiner must be inclified at 1 X Yes 2 □ No Director Columbia Maryland Howard 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Introortant: If Item 27 is marked other than "natural, or items 23a or 2, any lajury or other traumatic event, the Medical Examples or 2, once. 21044 USA 5050 Durham Road West Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3[™] Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Nursing Assistant Private Duty llth 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) å Harry Battie Lillie Farmer 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5050 Durham Rd. West Columbia, Md. 21044 Eunice Jones/daughter 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burlal 2 Cremetion 3 Removal from State 4/11/98 Schnectady, NY 4 ☐ Donetion 5 ☐ Other (Specify) Evergreen Cemetery 22. Name end Address of Fecility Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licen Wash., DC 20001 389 Rhode Island Ave., NW 23e. Pert1. Enter the disease, or indication's that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List on one cause on each line. Approximete Intervel Between Onset end Death Physician As piration /Medicai Grs Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician and s the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequenca of): attending esn 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 s 1 Yes 2 No certificate 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide 24 hours a edical 29a. Certifier 1 🚰 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c. License number D37013 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) #210 11055 Lettle Patrixent Plenn. Columbia, Mo 210-44 Bruck Conger,
31. Dete filed (Month, Day, Year)
APR 08 1998 MA

State Registrar 32/Registrar's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ELNORA HAMLETT 8:30PM April 1998 6, 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Sinai Hospital of Baltimore Baltimore If Undar 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1□M 2 F Months Halifax Co., Va. Yrs. 106-30-1329 60 Oct. 01,1937 Usual Residenca of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥□ Yes 2□ No Maryland **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3811 North Rogers Avenue 21207 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas XXNo If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Naver Married 2 ☐ Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Federal Government 12th Claims Clerk 18 Mother's Name (First Middle Maiden Surnama) 17. Father's Name (First, Middla, Last) Zachariah Pointer Geneva Brandon 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherri Holley/daughter 20b. Place of Disposition (Name of cametery, crematory or other place) Reistertown, Md. 21136 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/11/98 Church Cemetery Alton, Va. 22. Name and Address of Facility Frazier's Funeral Home, Inc. 21. Signature of Funeral Servica Licensi 20001 389 R.I. Avenue, NW Washington, D.C. 23a. Part1. Enter the disease, or commencations shock, or heart failure. List only one cause not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onsat and Death Immediata Cause (Final 4 days disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Myelodysplastic Syndrome 4 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequenca of): Chronic Myelogenous Leukemia 4 weeks Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

Directo

Funeral

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Completed

1 and 2 should be filed within 72 hours efter deeth with the Maryland Health and Mantal Hygiene.

Baltimore, Maryland 21215-0020

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Health mm 27 |

Important: If It any Injury or o **Jepartment**

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Examiner SE Certification:

Physician/Medicai p Completed Be 10

physician end the bural-transit use 0 signed by the e should should page 2 is certifice director, i this funeral

The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. Attending Physician: death. after death.

Director: A in 24 hour.
The Funerel Direction by Hospital 24 hours a

To the Hosp within 24 ho To the Fune completely fi Registrar

edicai

Drory Tendler, MD 31. Date filed (Month, Day, Year) State

25. Was case referred to medical examiner?

1☐ Yes 2☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

Investigation

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. 29c. License number

28c. Injury at Work?

29d. Date signed (Month, Dav. Year)

1 □ Yes 2 □ No

AS2402321-DT-9020

1 ☐ Yes 2 ☐ No

April 7, 1998

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1□ Yes 2 No

28d. Describe how Injury occurred

26. Place of Death (Check only one)

Baltimore, MD

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

2401 W. Belvedere Avenue

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

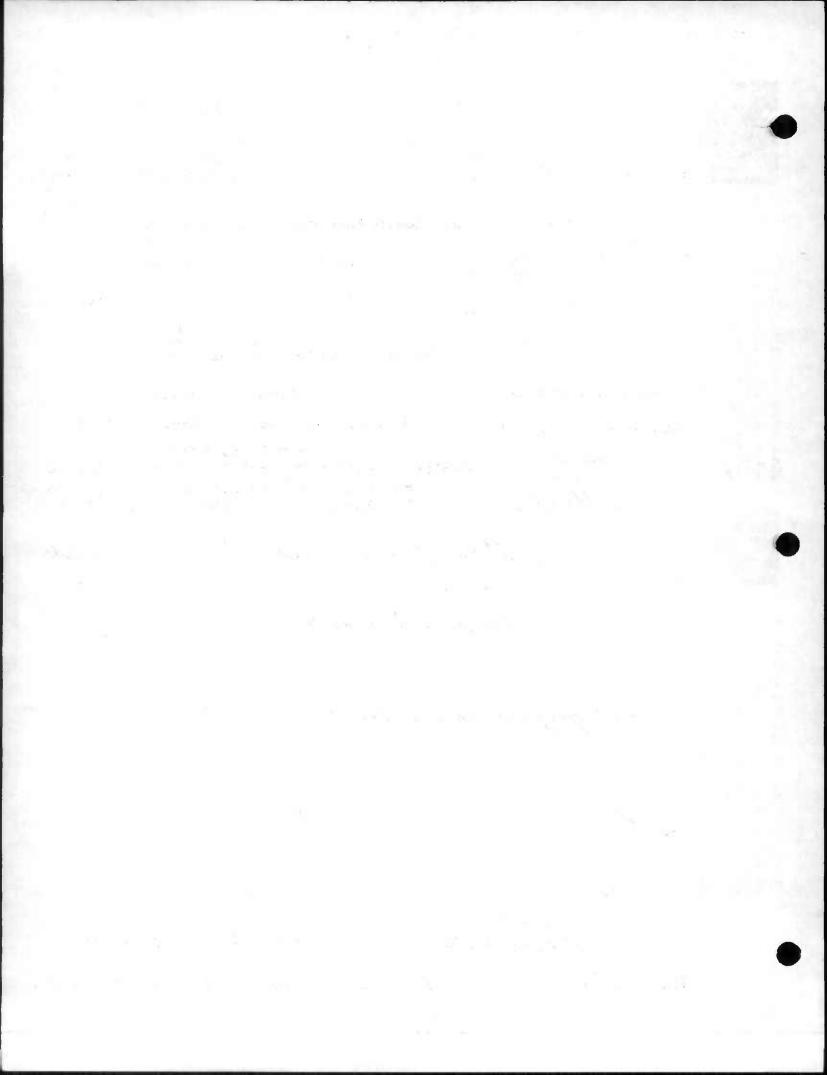
28b. Tima of

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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BE US			12. Wes Decedent Ever In U,S Armed Forces?	S. 13. Wes Dec	edent of Hispenic Origin? (ecify Cuben, Mexican, Pue	Specify Yes or No-	14. Raci	a - American Indien, ck, White, etc.
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injur		21. Signature of Funeral Servica Licanse	ee //	peake Ci	remation Ce	enter	Stever	nsville,MI
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Treva Catherine Humbert April 6, 1998 9:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lookabout Care Manor Westminster Carroll 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Days Yrs Director 87 199-05-9359 Nov. 10, 1910 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Medical Examiner must be notified at Westminster 1 Yes 2 No Director Carroll 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? ö 67 Timber Ridge Drive 21157 United States items 23a Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. should be filed within 72 hours after of Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: by 3 1 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) worker shoe manufacturer permit. Pages 1 end 2 should be file Department of Health and Mental Hy, important: If item 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Horatio Fleischman Roxie Utz 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Humbert, son 112 Highland Road, Westminster, MD 21158 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/09/98 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Pleasant Valley, MD 21. Signature of Funeral Service Licensee 22. Pritts Funeral Home & Chapel 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 412 Washington Rd., Westminster, MD 21157 Approximate Interval Between Onset and Death **Physician** Intracercloral loleed /Medical Immediate Cause (Final month disease or condition resulting in death) Examiner riensi -transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting In death) Last ue to (or as a consequence of): and ettending physician for use es the burie Physician/Medical Due to (or es a consequence of): signed by the el Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 0010 þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy peen has 1 ☐ Yes 2 No certificate 1 Yes Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 135:5100 Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Dev Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) á 4 - Homicide within 24 hours efter To the Funeral Dira completely filled in b Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certitier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

death (flam 2

Whi Davidson Re

32. Registrar's Signature

Cross Roads

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State Registrar

To the

Maryland

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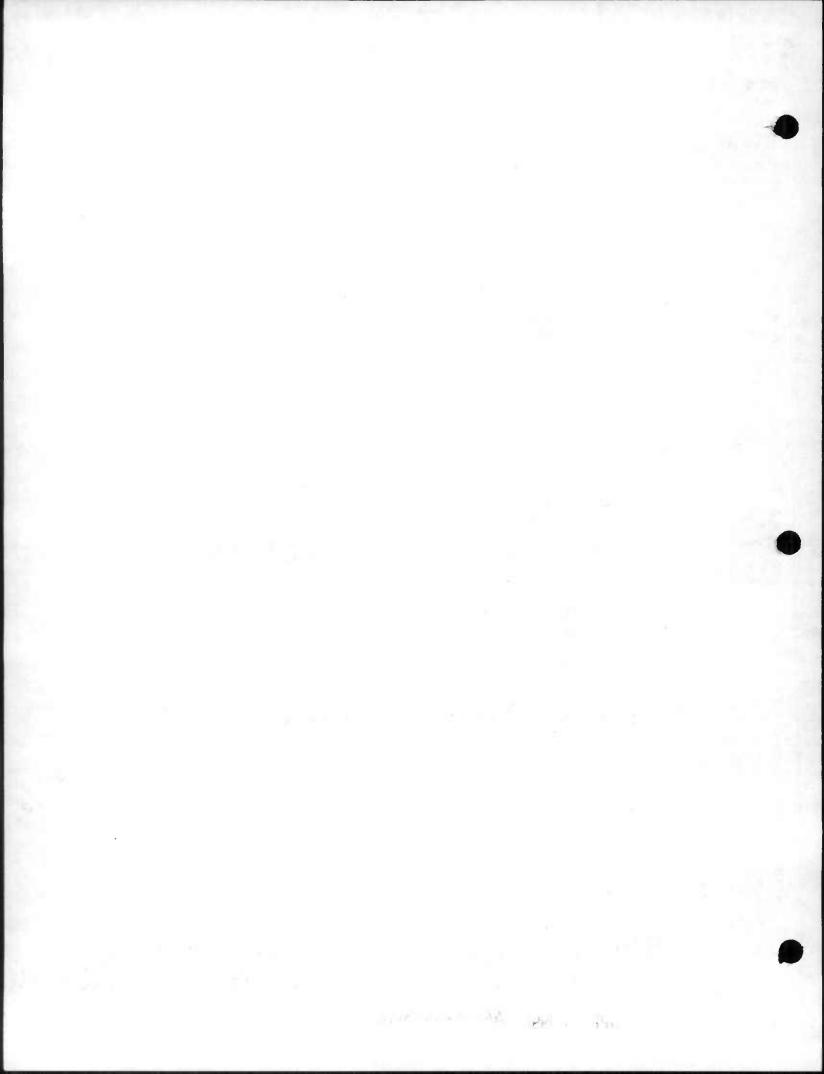
Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

The law requires that the death certificete be



B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

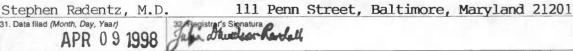
JOHN R. HERRITT

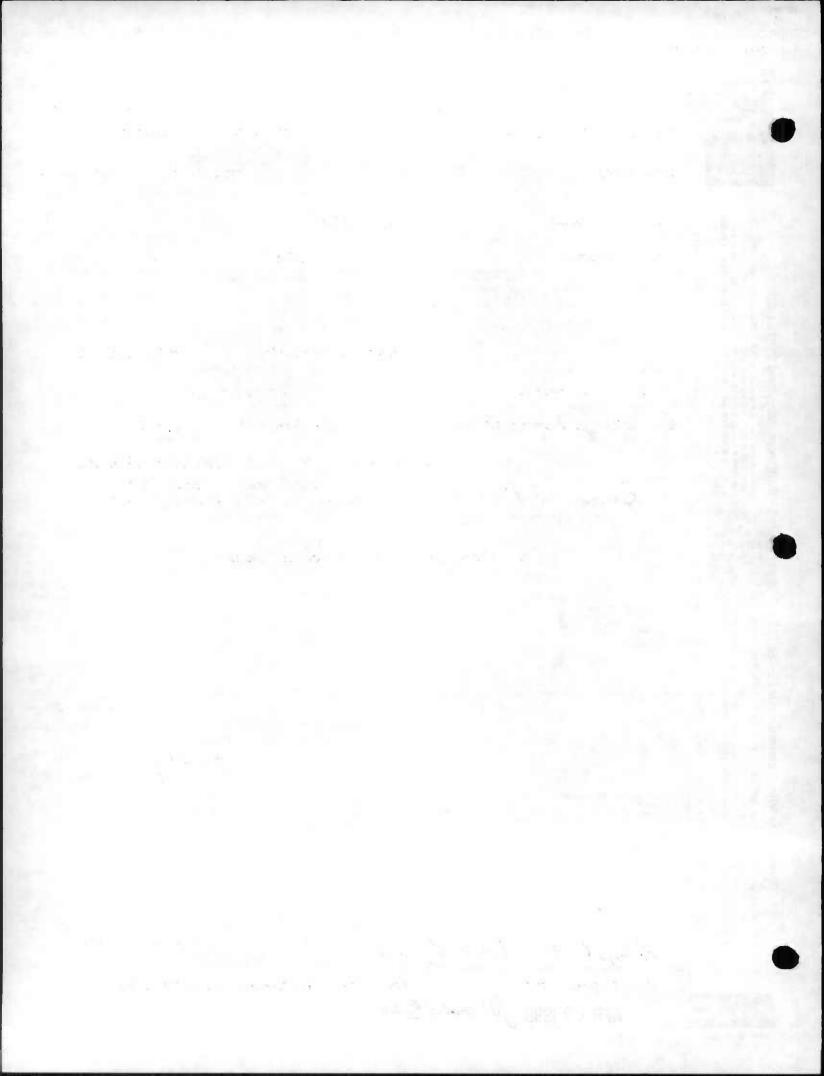
State of Maryland / Department of Health and Mental Hygieneg

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Examiner	4a Facility Nama (If not institution CARROLL COUNTY	giva street and num GENERAL	hospital			4b. City, Town, o WESTMI	or Location of Deat NSTER		y of Death	
Funeral Director	5. Social Sacurity Number 165–20–7633	6. Sax 1☐XM 2☐ F	7. Aga (In yrs. las 71	st birthday) Yrs.	If Undar 1 Yaa Months Day		n. (Month, D.	rth ay, Yaar) 2, 1927		olaca (Stata or Foreig otry) Sylvania
ž	Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City,	Town or Loca	ntion			HC 0.0	1	Od. Insida City Limits
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ect popular	10e. Street and Number	71.1		Sy.	10f. Zip Coda			10g. Citizen of	What Cour	atry?
P 20	806 Lee Avenue					21784				
ner mus	11. Marital Status	12. Was Deca	dant Evar In U,S.	13. Wa	as Decedant of		(Specify Yas or N		S.A. ce - Amaric	can Indian,
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event.	17. Fathar's Nama (First, Middla,	.ast)				18. Mothar's N	ama (First, Middle	a, Maiden Suma	ma)	
	John A. H	Merritt				Loui	se Meng	ee		
r is marked other treumatic event, I To Be Co	19a. Informant's Name/Ralations	nip (Type, Print)		19b. Mailing	Addrass (Stra	at and Number or			n, Stata, Zip	Coda)
17 tr	Mrs. Zelda I. H	Merritt (W	ife)	806 L	ee Aven	ue Sykes	ville, M	D 21784		
r other	20a. Mathod of Disposition	o Company of them 6	CRE	ce of Disposit	tion (Neme of story or other p	_	Data	20c. Location	- City or To	own, Stata
IT O	1 X Burlal 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (Sp			e View	Mem. P	Park	4/11/98	Sykesv	ille.	MD
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or the buriel-transit but the buriel-transit buriel	Sequantially list conditions, if any, leading to immediata cause. Enter Undarlying Ceuse (Diseasa or Injury	b	Dua to (or a	as a consaque	ance of):					
S se	that initiated evants rasulting in daath) Last	d	Dua to (or a	is a consaque	nnce of):					
d for us	Part II. Other significant conditio	ne contributing to de-	ath hut not result	ing In the und	ariving cause	nivan In Part I	23h Did	tobacco use o	ontribute to	o the cause of death
gned by the ettenc be deteched for us by Physician	Part II. Other significant condition	is combuning to de	atti bot not rason	ing in the tho	arrying causa	givan in Patti.		Yes 2□No		bably 4 🖔 Unknow
should should							perl	s an eutopsy formed? ECTION	ev	rara autopsy findings vailable prior to empletion of cause death?
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n 24 hours effer death. • Funeral Director: Affer it pletely filled in by the funera edical Certification:	3 ☐ Sulcida 6 ☐ Could r 4 ☐ Homicida datami	ned Zoa. Place	of Injury - At hom g, atc. (Specify)	na, farm, stree	et, factory, offic	20		(Streat and Num own, Stata)	nber or Run	al Routa Number,
Funer Funer tely fill	29a. Cartifiar 1 Certifyin (Check only one)	Physician: To the texaminer: On the beand mann	sls of axaminetio	edge, death on and/or Inve	occurred at tha stigation, In my	tima, date and pla y opinion, daath oc	ce, and dua to the curred et the tima	a causa(s) and n , date and place	nannar as s , and dua t	stated. o tha ceuse(s)
To the comple	29b. Signatura and titla of certifiar					nsa number		29d. Data sign		
	30. Nama and address of person	h M	and death into	5 M		C.M.E		APRIL	7, 19	998
	So. Ivalita and address of person	ALIO COMPINIED CARS	or needly (Hell) 5	was (Type, P	410)					

State Registrar

31. Data filad (Month, Day, Yaar) APR 09 1998





The law requires that the death cartificate be axecuted attanding physician efor usa as the burielsigned by the a page 2 Aftar this cartificate the Hospital or Attending Physician: director. filled in by tha funaral s after death.

within 24 hours a
To the Funeral C
completely filled

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Funeral

Director

28a-f show

6 items 23a

traumatic event, the Medical Examiner, must be notified at

"natural", or

Department of Haalth and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Ma once.

Physician /Medical

Examiner

tha Meryland

Peges 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0020

State Registrar

Medical

31. Data filad (Month, Day, Yaar)

29a. Cartifiar (Check only one)

29b. Signature end title of certifian

30. Nama and address or pr who complated causa of daath (Itam 23a) (Type, Print) RODRIGUEZ AURELIO

32. Registrar's Signatura

1 Certifying Physicien: To the best of my knowladge, daeth occurred at the time, deta end placa, and due to the causa(s) and mannar as steted.

2 Medical Exeminar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and placa, and due to the causa(s) and mannar stated. 29c. License number

29d. Date signed (Month, Dey, Year)

22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()

	Certificate of Death	Reg.	No.	161	41
Dhysiolon	Decedent's Nama (First, Middle, Last)	2. Date of Death Month		aar in-	e of Death
Physician /Medical	CLARICE ANN JOHNSON	APRIL O	-	78	HND-
Examiner	The state of the s		4c. County of		(
				GEORE	
eral	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Dey, Ye			
tor	578-56-8996 75 Tris.	December	21,	Virgin	ia
	10a. State 10b. County 10c. City, Town or Location			10d. Inside	e City Limits
Director	Maryland Prince Georges Fort Washington			1 📉	ras 2□No
Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Cifizen of Wh	at Country?	
	1828 Taylor Avenue 20744	Uni	ted St	ates	
Dere	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race -	Amarican Indian	٦,
F	1 □ Navar Married 2007 Married 1 □ Yas 2 □ TNo	to nicali, etc.)		Whita, atc.	
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ▼No Specify: Year or Datas:		Specify:	Black	
Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	16b	. Kind of Busi	ness/Industry	
nple	(Specify only highest grade completed) [Give kind of work done during most of wo life. DO NOT use retired] [Give kind of work done during most of wo life. DO NOT use retired]	D.	C. Go	vernmen	t
Co	12th grade Secretary			f Aging	
Be		me (First, Middle, Meid	den Sumeme)		
20	Paul Chaney Annie			(unkn	lown)
	19a. Informant's Name/Relationship (Type, Print) (daughter)				20744
	Diane Elizabeth Broadus 1828 Taylor Avenue, Fo	D		Ity or Town, State	
	1 Burial 2 Cremation 3 Ramoval from State cemetery, cremetory or other place) April	6,1998			
	4 Donation 5 Other (Specify) National Harmony Memorial			r, Maryl	
DUCE	21. Signature of Exploral Service Licensee 22. Name and Address of Facility Roll				
	Mohat a Smith 1661 Good Hope Ros	ad,S.E.;Was	shingto	n,D.C.	20020
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdie shock, or heart failure. List only one cause on each line.	c or respiratory arrest,			Between
ian				Onsat a	ind Death
cal ner	Immediata Causa (Final disease or condition a HYPERTENSIVE ARTERIOSCUEROTIC C.	ARDIOVASCI.	JLAR D	PISEAGE	
	Due to (or as a consequence of):				
edical Examiner	b				
al Examir	Sequentially list conditions, figure 1 any leading to immediate				
<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.				
de	that Initiated avents				
5	d				
Physiclan/I					
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.			ribute to the cau	b .
F		1 U Yes	2□ No 3	3 Probably	4 Unknow
Completed by		24e. Was en a	utopsv	24b. Were autor	osy findings
ete		performed		available processing	
m du			h-1	of death?	
		1 □ Yes	2 No	1 🗆 Yes	2 No
Be	examiner? Hospital: Other:	eath (Check only one)			
5	1 Inpatient 2 Er/Outpatient 3DOA 4 Nursing	Home 5 Residence 28d. Describe how			
Certification:	27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of Unique at Work? 1 Nature investigation M 1 1 9s 2 No	200. Describe flow	injury occurren		
Ca	3 Suicide 6 Could not be	28f. Location (Stree	at and Number	r or Rural Route	Number
ŧ	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S		Of Floral Floral C	realition,
2	200 Codifice 1 Condition Physician To the heat of my translation death accurred at the time date and place	and due to the source	oa/a) and man	nor or stated	
edicai	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place (Check only one) 1				ise(s)
Medical Certifical	one) and manner shated. 29c. License number	29d.	Date signed	(Month, Dey, Ye	ar)
5	> / WILL MARCHON I MUT CORDER				
1	10000000 July 1000 155954	ME	HL O	12, 1998	
)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	01500		12, 19198 KYLAND	ano.
/_	MARIO F. GOLLE JR MP 3001 HOSPITAL PRIVE	- HEVELL	7 IMA	TYLANI	1.10 18
State	31. Date filed (Month, Day, Yeer) 32. Registrar's Signature				
gistrar	APR 06 B38				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 50Aa ounty of Deeth 4b. City, Town, or Location 4a Facility Nama (If not institution, giva straat and number) MANOR 0 MA 10 If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yeer Birthplaca (Stata or Foraign Country) 6. Sax Days 100M 2□ F Months 20-12-1168 П Yrs. Usual Rasidanca of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No D.C. N/A Washington 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 401 K Street N.W., U.S.A.
14. Race - Amarican Indien, # 517 20001 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yeer or Datas: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 □ Navar Marriad 2 □ Marriad 1 Yes 2 No Specify: Specify: Black 3 ₩ Widowad 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) College (1-4or 5+) Elementary/Secondary (0-12) 6th Laborer Construction Company 18. Mothar's Nama (First, Middla, Malden Surname) 17. Father's Neme (First, Middle, Last) Pete Joyner Georgiana Perkins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 49 Bates Street N. W., Washington, DC 20001 Willie Joyner - Son 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Fort Lincoln Cemetery Brentwood, MD 21. Signatura of Funaral Sarvice Licansas 22. Nama and Addrass of Facility Marshall's Funeral Home, Inc. 23a. 241. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failura. List only one causa on each lina. Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in death) a Metastatic Carcinoma months Dua to (or as a consequence of): Urinary Bladder Carcinoma months Due to (or as a consequence of): Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequanca of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Dementia 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be 10

Funeral

Director

7 is marked other than "natural", or items 23s or traumatic event, the Med tal Examiner must be or

permit. Pegas 1 and 2 should be filed within 72 hours after death v Departmant of Haaith and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23s any Injury or other traumatic event, tha Medical Examine must applie.

Baltimore, Maryland 21215-0020

with the Maryland r 28a-f show

> Examiner Physician/Medical 88 USB 2 Completed Be 0 Certification:

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edical within 24 hor To the Fune completely fi the 0

Hospital

Registrar

31. Data filed (Month, Day, Year) State APR 09 1998

29a. Certifiar

(Check only one)

29b. Signatura and titla of certifiar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case rafarred to madical 26. Place of Death (Check only ona) examinar? Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascriba how Injury occurred 28c. Injury at Work? 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 | Homicida

> 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

> > D 15405

29c. License number

29d. Data signed (Month, Day, Year) April 6, 1998

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

Cezar A. Lopez, M.D. 18111 Prince Philip Drive, #104, Olney, MD 20832

32. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death April 8, Day 1998 Year 2:45PM Kreplin Suzanne 4b. City, Town, or Location of Death 4a. Facility Nama (If not Institution, giva street and number) 4c. County of Death 1409 Jefferson Rd. Ft. Washington Prince George's H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For Months | Days | Hours | Min. | March | 13,1929 | Newton, Mass. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foraign 1 □ M 200 69 Yrs. 003-18-2089 Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ¶XYas 2 No Maryland Prince George's Director Ft. Washington 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whai Country? 20744 1409 Jefferson Rd. USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 22 DNo If Yes, Give Yaar or Datas: 13. Was Decedeni of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, aic.) 14. Race - American Indian, Biack, Whita, aic. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White py 3 ☐ Widowed 4 ☑ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collaga (1-4or 5+) Water Safety Instructor Teaching&Coaching 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meidan Sumama) Richard Kenneth Townsend Katherine Huntley 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Lydia Kirby/Daughter 212 Lakeridge Dr. Stephens City, Va. 22655 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Metropolitan Crematory 4/9/98 Alexandria, Va. 22. Nama and Address of Facility George P. Kalas Funeral Home do 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 ff). Enter the disease, or complications took, or heart failure. List only one cause or complications that crusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Between Onset and Death Immediaia Causa (Final disaasa or condition resulting in deeth) Examiner roscler Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or Injury that Initiated events rasulting in daath) Last Due to (or as a consequence of) Physician/Medicai Dua io (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🗓 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 28. Placa of Death (Check only one) Hospitel: 1 ☐ inpatiant 2 ☐ ER/Ouipailent 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Neturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Piace of Injury - At homa, farm, street, fectory, office building, etc. (Spacify) 4 Homicida 12 Certifying Physician: To tha besi of my knowledga, daath occurred at tha time, dete and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daath occurred at the time, dete and place, and due to the cause(s) and mannar stated. 29e. Cartifiar Medical 29c. License number 29d. Daia signed (Month, Day, Year) 29b. Signature and titia of certifier 007287 11418 LIVINGSTON Rd 30. Name and addrass of person who complated causa of daath stam 23a) (Typa, Print)

FOUT WASHINGTON, Md. 20744

Certification:

31. Date filed (Month, Day, Year) APR 1 0 1998

R.A.MC

32 Plagistrar's Signaiura

CONNAWGAY

DHMH 16 Rev 6/95

Registrar

Physician /Medical Examiner

Funeral Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examine mast be notified as

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760, Attanding Physician: Hospital or Attandil
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month Day **Physician** BABY GIRL KAMARAH 24, 1998 MARCH 5:00PM /Medical 4b. City, Town, or Location of Death 4a. Fecility Nema (If not institution, give straet end number) 4c. County of Deeth Examiner PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY If Under 24 Hrs. Hours Min. If Undar 1 Year 5. Sociei Sacurity Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Months Deys Vrs Director 9 CHEVERLY, MD N/A MAR 15, 1998 Usual Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Yas 2 No Director MD PRINCE GEORGES LANDOVER 10e. Street end Numbar 10f Zin Code 10g. Citizen of Whet Country? permit. Pages 1 end 2 should be filed within 72 hours after deeth v Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must. and. UNITED STATES OF AMERICA 20784 7018 TAYLOR TERRACE Funeral 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Rican, etc.) Wes Dacedant Evar in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yas, Giva Year or Dates: 1 Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 ☐ No by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame Be ANTONIO TRICE SAIBATU KAMARAH 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 7018 TAYLOR TERRACE LANDOVER, MD 20784 SALLIE ECHOLS / GRANDMOTHER 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) HARMONY MEMORIAL PK 3/30/98 LANDOVER, MD ALEXANDER S. POPE FUNERAL HOMES disease of complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, allure. Un only one cause on each line. 5538 MARLBORO PIKE FORESTVILLE, MD 20747 Approximete fnterval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) . DUERWHELMING SEPTIBEHIA Examiner Due to (or es e consequence of): Physician/Medical Examiner PREMATURITY physician end the bunal-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immadiate ceuse. Enter Undarlying Ceuse (Diseese or Injury that initiated avents rasulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): as ettending p for use as ed by the e P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown been signed be should be detr Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to complation of causa of deeth? 24a. Wes en eutopsy performed? Completed page 2 certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours efter death Funeral Director: 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in Hospital 29e. Certifier 🛣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. completely (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. To the within 2 29b. Signeture end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Mehnus Abedin -D3818d 98 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Prince Deages Commun & 31. Dete filed (Month, Dey, Year) 32 Registrar's Signeture State Jaki Shudear Revell APR 06 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 120 PM Lee Mane April /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Greater Laurel Regional Hospital Prince George's Laurel 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 25 F 77 Director 227-26-9706 10-15-20 South Carolina Usual Residence of Decedent the Manylend 10b. County 10c. City, Town or Location 10d. Inside City Limits flam 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avent, tra Medical Examiner name to notified at Maryland Prince George's Laurel No Yes 2□No Director 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 14016 Williamson Avenue 20707 USA Funeral 12. Wes Decedent Ever in U,S. 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Maritel Status permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iter any injury or other traumatic avent, the Medical Experimento. Bleck. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯XONo Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Housekeeping Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Durant Jones Ola Hickerson 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley M. Jones/Daughter 14016 Williamson Avenue, Laurel, Maryland 20707 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete ty Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland National Cem. 4/9/98 Laurel, Maryland 21. Signeture of Funerel Servica Licanses 22. Neme end Address of Fecility J. B. Jenkins Funeral Home 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest,

Approximate shock, or heer feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es a consequença of) Examiner failur certificate be executed buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events and Box 68760. ettending physicien javella Physician/Medicai the Due to (or es a consequence of): resulting in deeth) Last 98 Coma use for Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown Ď 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peed page 2 s 1 Yes 2 No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Opatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Dete of injury (Month, Dey Yeer) 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 De Neturel 2 Accident 1 Yes 2 No 24 hours efter deeth.

Funeral Director: A 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in Hospital Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. Medical 29a. Certifier pletely (Check only one) the th 29b. Signeture end title of cartif 29c. License number 29d. Dete signed (Month, Dey, Year) 0 Laurel, MD 20707 nce George St, State Registrar

AND SERVICE SERVICE

Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED #'s 5.6.7.&8.PER F.H. PGC 4-9-98 cr Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Year **Physician** 1998 Lervera MARCH 28 9:45p /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not Institution, give street and number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex 1X M 2□ F **Funeral** 579-54-3613 55 Yrs. Director Unione of Decedent Halenowa the Meryland 10d. Inside City Limits 10e. Stete 10h County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 Yes 2 □ No Director Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States permit. Pages 1 and 2 should be filed within 72 hours after deeth a Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or frems 23e any injury or other traumatic event, the Men 21218 1 East University Parkway Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Unknown Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 5+ years Science Teacher Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Althea Saunders Cervera R. Little, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 1722 13th St., N.W. Washington, D.C. 20009 Lauren Bailey- Niece 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Locetion - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Cemetery 4/11/98 Suitland, MD 22. Name end Address of Fecility Stewart Funeral Home, Inc. 21. Signature of Funerel Service Licensee 4001 Benning Rd., N.E. Washi
23a Full 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, utilick, or heart failure. List only one cause on each line. 4001 Benning Rd., N.E. Washington, D.C. 20019 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting In deeth) 16 days End - stack rencl (Due to (ones e consequence of) Examiner Examiner physician end is the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the deteched signed by t 1 Yee 2 No 3 Probably 4 Unknown cardiomyopathy 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? multiple cerebrovoscular accidents upper gastroniestral bleed due to varices

25. Was case referred to medical examiner?

Hospital:

Hospital: 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident ofter death Director: / 3 in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) in 24 hou... the Funeral Direction by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 29e. Certifier edical

To the Within 2

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(Check only one)

29b. Signatus

Registrar

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2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted.

29c. License number

29d. Date signed (Month, Dey, Yeer) March 28 1998

orson who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Hospital Philip Seo,
31. Dete filed (Month, Dey, Yeer) T Reconsister's Signeture

APR 091

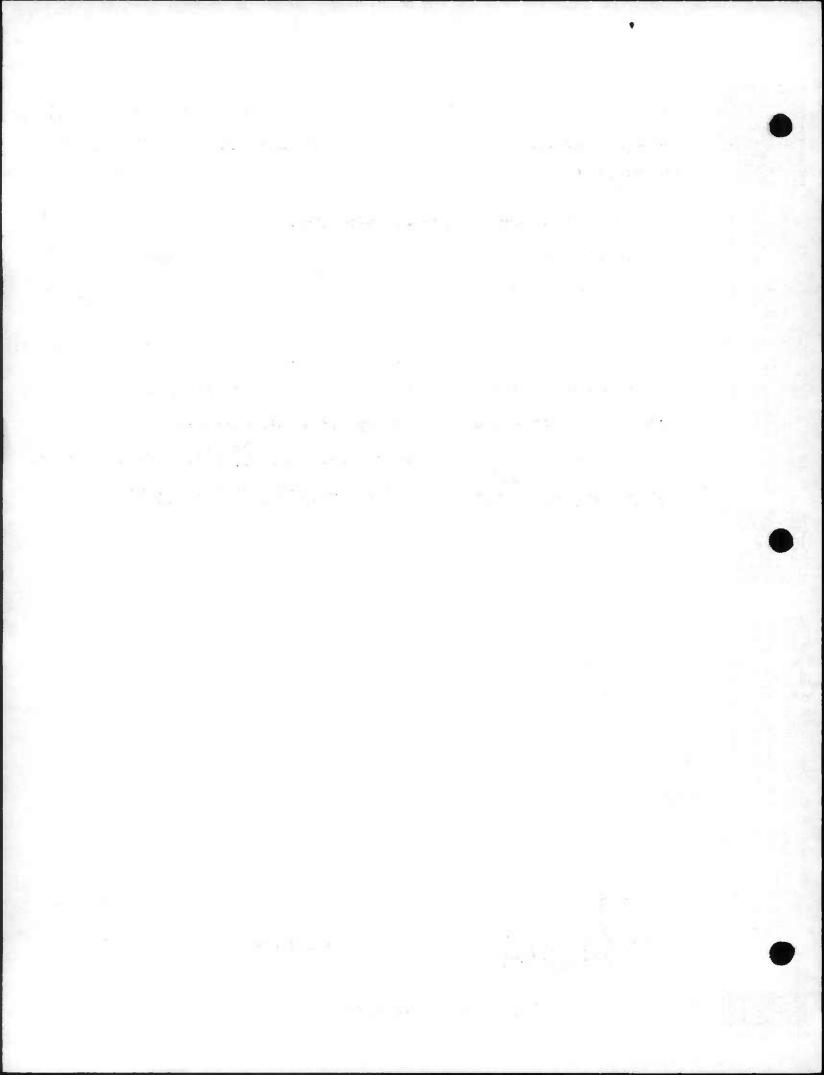
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State of Maryland / Department of Health and Mental Hygiene

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	Dhuaini		Decedent's Name (First, Middle, Last)				2. Dete of Deetl Month	h	3. Time of Deeth Year
	Physici /Medi		John Webster	Lippert	Sr.		April 1	4 199	
	Examir		4e. Fecility Neme (If not Institution, give street e	ind number)		4b. City, Town, or		4c. County o	f Deeth
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	Funeral Director		5. Sociel Security Number 215-09-5267 Usual Rasidence of Decadent	7. Age (In yrs. lest b	birthdey) If Under 1 Ye Months Dey	ar If Under 24 Hrs.	8. Dete of Birth (Month, Dey,	Year)	9. Birthplace (Stete or Foreign Country) Maryland
	land		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	ter death with the Marylan items 23a or 28a-f show inst. must be notified at	tor	Maryland Queen An	me's Oues	enstown, M	ID 3			1 ☐ Yes 2€ No
	or 284	Director	10e. Street end Number		10f. Zip Code		10	g. Citizen of Wi	het Country?
	th wi		106 Wye View Rd.		2165	8		USA	
	daa	Funeral	11. Meritel Stetus 12. Wes	s Decedent Ever in U.S. ned Forces?		of Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-	14. Reca	- American Indian, , White, etc.
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5-0	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade comp.	leted)	Ba. Decedent's Usuel Occ (Give kind of work dor	ne during most of wor	king	6b. Kind of Bus	lness/industry
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re,	the state of the s		20e. Method of Disposition	20b. Piece	106 Wye V of Disposition (Name of tery, cremetory or other p	Tew Ru.	Dete	20c. Location - C	City or Town, Stete
E	Paga ento nt: if ry or		1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel 4 ☐ Donation 5 ☐ Other (Specify)	from State	lery, cremetory or other p	nace)	April		, Maryland
Baltimore,	permit. Pagas 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Licensee	10	OO Name and Ad	tenne of Facility			
			23a. Part 1. Enter the disease, or completations shock, or haert failure. List only one caus	Jerpu	106 Sha	mrock Rd	., Ches	ter, M	D 21619
1	Physician		shock, or haert failure. List only one caus			25		ist,	Approximate Intarval Between Onset and Death
	/Medical Examiner		Immediete Ceuse (Finel diseese or condition resulting in deeth) a.	Coron	ary art	ery De	rease		years
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	icata be executed physician and s the burial-transit	xar	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	consequence of):				years
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m	death a atten	cla	Pert II. Other significant conditions contributing	a to death but not resulting	In the underlying cause	given in Part t	23h Did to	hacco use cont	ribute to the cause of death?
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Records,	been s	Completed					24a. Wes ar perform		24b. Ware autopsy findings aveilabla prior to completion of cause of death?
	ysician: Tha lav is cartificata has director, paga 2	EO					1 ☐ Ye	s 2 No	1 ☐ Yes 2 ☐ No
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>	Physician: r this cartific rrai director,	10	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/C	Outpetient 3 DOA	Other: 4 Nursing H	ome 5 Reside	nce 6 Other	(Specify)
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sio	endir eath. or: Al	catle	2 Accident investigation			☐ Yes 2 ☐ No			
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi complataly filled in by the funeral	Certification:	3 Suicide 6 Could not be datermined 28a.	Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office	ea	28f. Location (Str City or Town	reet end Number , Stata)	r or Rurel Route Number,
	Hospit 24 hour Funer staly fill	edical	29a. Certifier Certifying Physician: 1 (Check and 20 Medical Examiner: On and	To the best of my knowladg the basis of examinetion a dimenner steted.	ga, daath occurred et the and/or investigation, in m	tima, deta and place y opinion, deeth occu	, and dua to tha ca rred at the time, da	usa(s) and man ite and pieca, ar	ner es steted. nd due to the ceuse(s)
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			30. Name end addrass of person who complated	d sause of deeth (Item 23e	(Type, Print)			,-10	•
				0. Box 458 G:		MD 21638	.		
	Sta	te		32 Registrate Signature		141			
	Dogietr		HEK TU IAAN	S CHIMA JAM	MANA THINKS A.				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** eister 13:45 Delle. 1998 05 ennic 04 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner arroll Carroll County General Hospital Westminster 5. Social Sacurity Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** 1 M 2MF Months Deys Hours Min Yrs. Director 213-74-8457 95 Nov. 7, 1902 Maryland Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 28a-f show / le marked other than "naturel", or items 23s or 28s-f show traumstic event, the Mooigal Examiner must be notilised as 1 Yas 2 No Carroll Westminster Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 709 Leister's Church Road 21157 United States permit. Peges 1 and 2 should be filed within 72 hours after death a Depertment of Health end Mentel Hygiene. Important: If Item 27 Is marked other than "naturel", or Hems 23. any Injury or other traumatic event, in Medical Economy man Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American indian, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify à 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home/Farm 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Nama (First, Middla, Last) Philip Wesley Rill Susie Jane Kelbaugh 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Lavena Basler, daughter 921 Leister's Church Rd., Westminster, MD 21157 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition natary, cremetory or other pleca) 04/08/98 1 Buriel 2 □ Cremation 3 □ Removel from State Leister's Church Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Westminster, MD 21. Signatura of Funeral Service Licenses 22 Name and Address of Facility Home & Chapel any in 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory errest, shock, or heart failure. List only one cause on each line. 412 Washington Rd., Westminster, MD 21157 Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) week Examiner Due to (or es e consequence of) Examiner DISBASE CORONARY ALTERY The law requires that the deeth certificate be asscuted physician and the bunal-trensit Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 80 attending 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Ö the signed by to 3 Probably 4 Unknown 0 1 Yes 2 No Division of Vital Records, 2 24b. Were autopsy findings aveileble prior to 24e. Wes an eutopsy performed? Completed peeu completion of ceuse of death? has 2 PNo certificata 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28e. Date of injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? Certification: After 5 Pending investigation 1 Maturai n 24 hours after death.
he Funeral Director: After plately filled in by the fun 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es stated. 29a. Certifier plately (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted. within 2 To the 29b. Signafure and titla of certifie 29c. Licensa number 29d. Date signed (Month, Dey, Year) ATTENDING

State Registrar

APR 08 1998

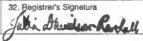
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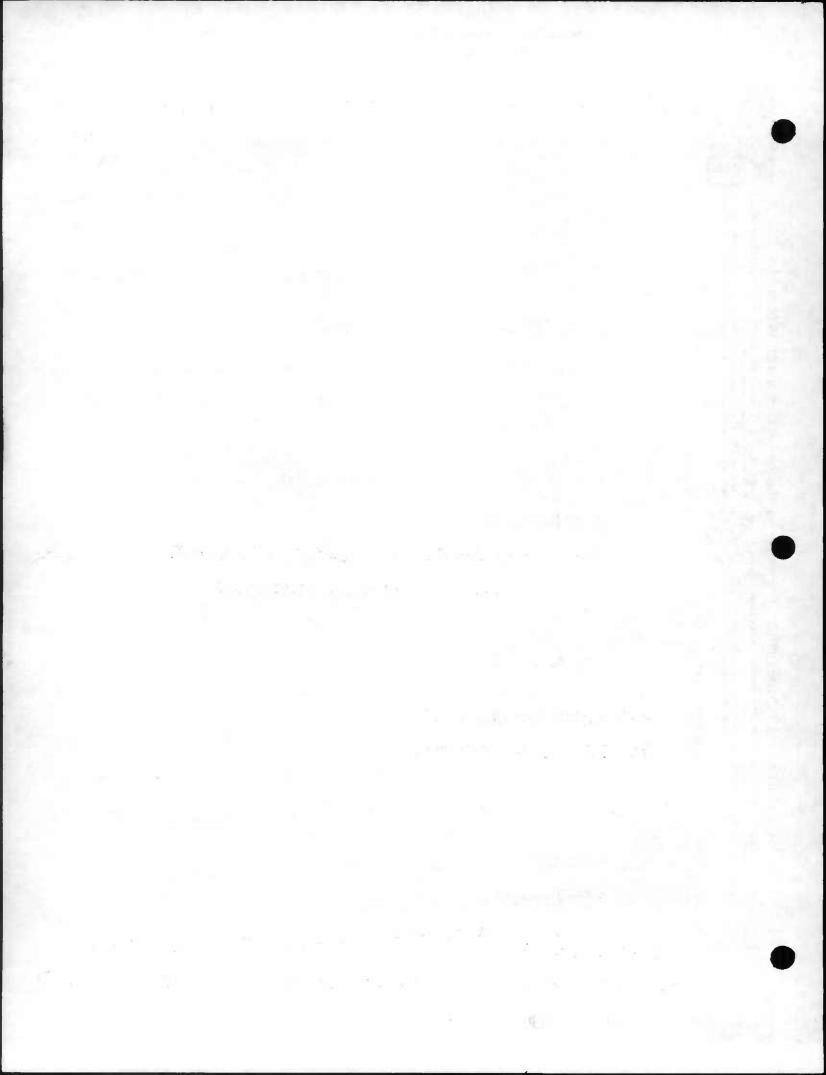
Neme end eddress of person who completed cause of death (item 23a) (Type, Print)

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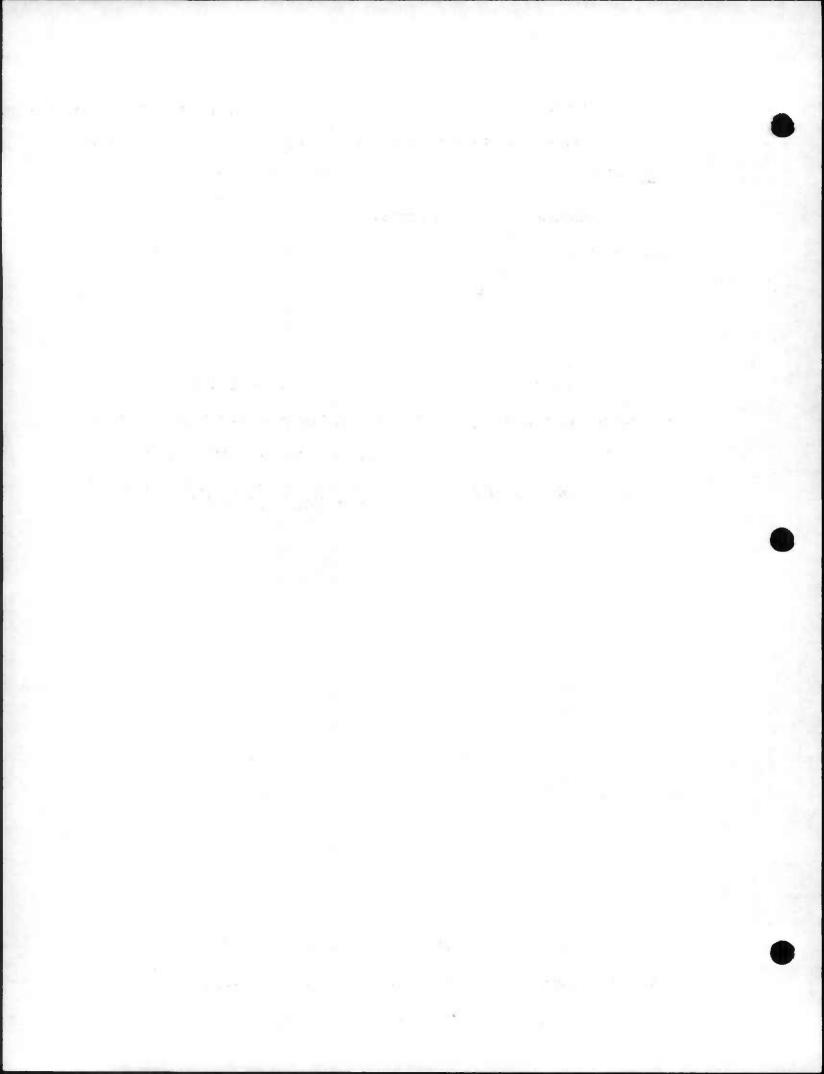
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904 WASHWARDN PD WESTMUSTER MD 21157



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Decodent's Name (First, Middle, Last) DONALD LINTON Donator Day Veer April 2 1998 1;26				Otate of IV	iaiyiaiiu	Certific		Death		Reg. No.	3 1:	2737	
DONALD D	Physic	ian	1. Decedant's Nama (First, Middla,	Last)					2. Data of De	eath		3. Tima of Death	
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D43003 4/3/98	To the To the Comp	Me	29b. Signatura and titia of certifier				29c. Licans	a number		29d. Data signa	d (Month, Da	y, Year)	
	, , , ,		M C W		e		D43	003		4/3/98			
			30. Name and addrass of person wh	o complated causa of	daath (Itam 23	3a) (Type, Print)				., 5, 50			
Nathan A. Dunsmore, M.D., 6701 N. Charles St., Baltimore, MD 21204		344					es St	., Balti	nore, MI	21204			
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98-1894-025 AM RICHARD

Physician /Medical

Examiner

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After this certificate has

funeral director,

or Attending Physician: effer death. Director: After this certific

To the Hospital c within 24 hours of To the Funeral D

law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

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Completed

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Certification: To

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / D

Department of Health and Mental	Hygiene	0	Ω
Certificate of Death	Dog No.	1	U

LES	SMAN						Certi	ficate	of	Death			Reg. I	No.)	61
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	Examiner	4a Fecility Neme		n, give street end nu	um <i>ber)</i>					4b. City, To		ocation of De. Le		4c. Count	,	h
	Funeral Director	5. Sociel Security 215-58-0	0601	6. Sex 1 M M 2 □ F	7. Age	(In yrs. lest birth	100//	f Under 1 Ionths	Year Deys	If Under Hours	24 Hrs. Min.	8. Date of 8. (Month, 1			9. Bird Co Mary	nplace (St untry) yland
	death with the Meryland ms 23e or 28e-f show maint be motified at neral Director	Usuel Residence of 10a. Stete Maryland	10b. County	ford		10c. City, Town	or Locat	ion		Pyle	svi	lle				10d. Insi
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21215-0020	be filed within 72 ho tal Hygiene. d other than "nature event, the Medical Be Completed	Elementary/Sec	ondary (0-12)	College	(1-4or 5- 2	+)				Couns	elo	r	U	.s. (Gove	nmen
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altimore,	Peges 1 an ant of He sant: If item ury or other			3 □Removal from	State	20b. Plece of I cemetery	, cremet	ory or oth	er ple		i !	Dete 4-7-98				Town, Ste
Balt	permit. Departr Importu any Inj	21. Signature of F	uneral Service	Grand A	/		22. N	eme end	Addre	ess of Feclli	nas	III Fur				

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7 Autumn Wind Ct., Reisterstown, Maryland 21136

20c. Location - City or Town, Stete

Towson, Maryland

2738

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2X No

3. Time of Death

8:55 P

23a. Pert1. Enter the disease, or complication, thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one cause on each line.

1317 Cokesbury Road, Abingdon, Maryland 21009 Approximete Intervel Between

Immediate Cause (Final disease or condition resulting In deeth)

(ir hosis

Due to (or es e consequence of)

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of):

Due to (or es e consequence of)

Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 25 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings eveitable prior to completion of cause of death?

Onset end Death

1 PYes 2 No 1 Yes 2□ No

25.	Wes case		to medical
	1 Yes	2 No	

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28. Place of Deeth (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify)

28d. Describe how Injury occurred 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Deeth

1 Maturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifie

29c. License number

OCME

29d. Date signed (Month, Dey, Year)

APRIL 05, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

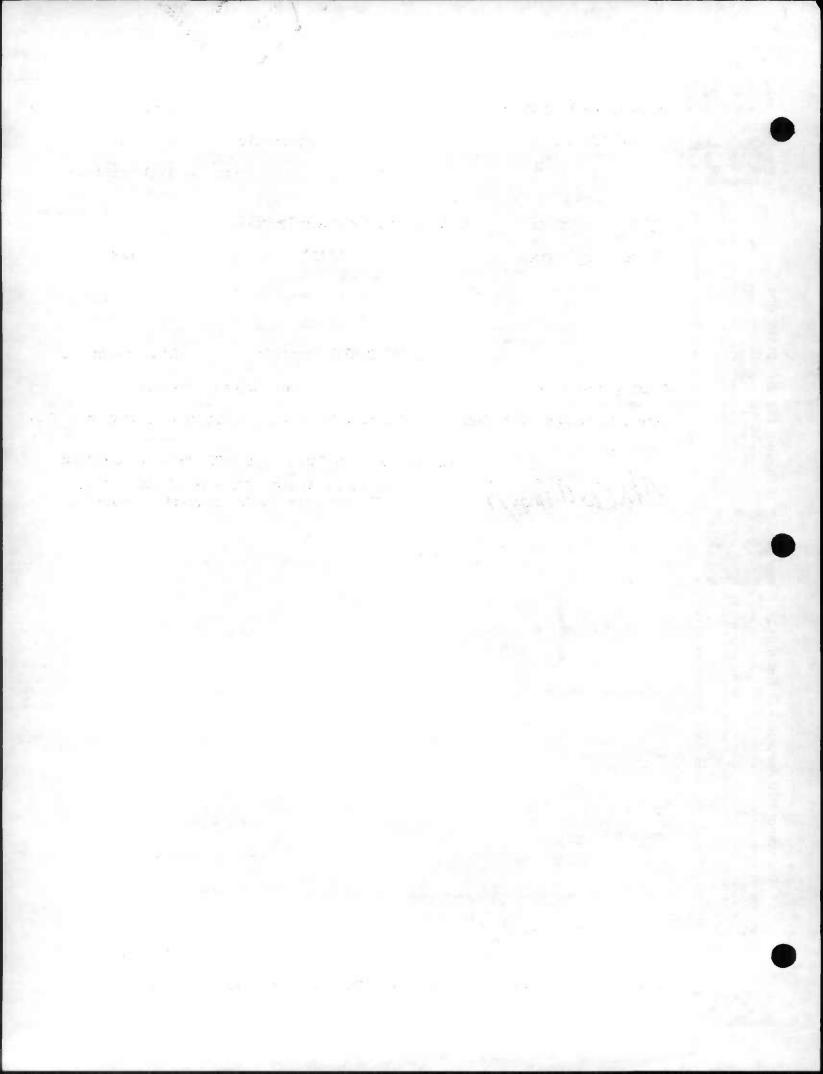
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6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Day, Year) 1998 APR 8

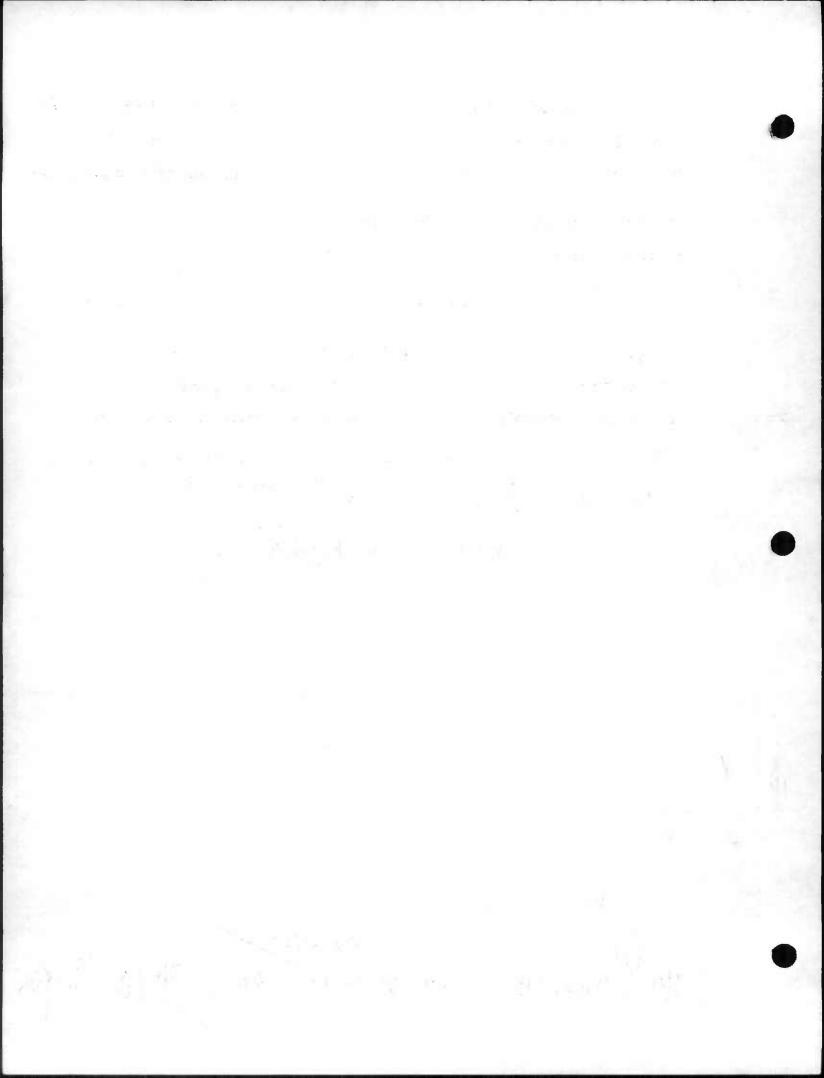
32. Registrer's Signature his Davoler Rardall



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth April 7, **Physician** 1998 Yeer 30 pm Doris Carroll Lyman /Medical 4a. Facility Nama (If not institution, give streat and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1425 Old Stepney Road Harford Aberdeen If Under 1 Year If Under 24 Hrs. 5. Sociel Security Numbar 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Deys Hours 1 □ M 2 X F 75 016-14-4220 Yrs Director 1922 Massachusetts Usuel Residence of Decadent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Department of Health end Mentel Hygiene. Important: or items 23a or 25a-f show any Injury or other traumatic event, the Medical Exeminer must be notified along other. 1X Yas 2 No Directo Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 303 Carter Street 21001 U.S.A. death Funerai 11 Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mentel Hygiene. Int: If Item 27 ie marked other than "natural", or ite 1X Yes 2 No If Yes, Give Yaar or Detes: 1945–46 1 Never Merried 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowad 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Registered Nurse Nursing 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Joseph Carroll Melanie Bissailion 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ona Lyman (Husband) 303 Carter Street, Aberdeen, Maryland 21001 20b. Plece of Disposition (Nema of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Purial 2 ☐ Cremation 3 ☐ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/13/98 Baker Cemetery Aberdeen, Maryland 21. Signature of Fifteral Sarvice Licansaa 22 Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 0 23a. Pert1. Entar the disease, or complications that crused the deeth. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heer feilure. List only one ceuse on sech line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disaesa or condition resulting in death) /Medical Examiner Due to (or as a consequenca of) Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequenca of): physiclan s the buriel P.O. Box 68760, Physician/Medicai Due to (or es e consequança of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to complation of cause of death? page 2 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Wes cass referred to medical Be 28. Pieca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Naturel er of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investiga 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 5 4 Homicide filled in within 24 hours at To the Funeral D completaly filled 1 dertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner as steted.
2 detection on the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner steted. 29e. Certifier Medicai 29b. Signeture and title of certifier 18 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day 1998 April **Physician** 6, 1:50 PM CORA В. MINOR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Sacred Heart Home Prince Georges Hyattsville Hours Min. 8. Data of Birth April 13,1903 5. Social Sacurity Number If Undar 1 Yaar 9. Birthplaca (Stata or Foraign 7. Aga (In vrs. last birthday) **Funeral** Virginia Months Days 1□M 2√2 F 183-12-0933 94 Yrs. Director Usual Rasidance of Decedant permit, Peges 1 and 2 should be filed within 72 hours after death with the Manfand Department of Health end Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, to Medical Esaminar must be not the contract. 10a. Stata 10h. County 10c. City, Town or Location 10d. Insida City Limits No Yas 2 No Directo Maryland | Prince Georges Landover 10f. Zip Coda 10g, Citizan of What Country? 10e. Street and Number U.S.A. 20785 709 Green Willow Place Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 27 ☐ No ff Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify:Black þ 3 AWidowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry 15. Dacedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) Housewife self-employed 7th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be James Thomas McDaniel Nellie Lewis 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 709 Green Willow Place, Landover, MD 20785 Geraldine Minor - Daughter 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Pisgah Baptist Ch.Cem 4-11 True Blue, Virginia 21. Signature of Funeral Service Licenses 22 Nama and Address of Eacility
Marshall's Funeral Home, Inc. MARIA 4217 9th Street N.W. Washington, DC 20011 tions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final Houte my ocardial infarction Sudden disaasa or condition rasulting in daath) Examiner Dua to (or a consequence of): Examiner theroscleratic heart disease CATS attending physician end for use es the buriel-transit law requires that the death certificete be executed Dua to (or as a consequence of): Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that Initiated avants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown serile dementia þ 24b. Wara autopsy findings avaitable prior to complation of ceuse of death? 24a. Was an autopsy performed? Completed certificate has b director, page 2 s 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas or Attending Physician: 25. Was cesa rafarrad to madicel axaminar? Be 26. Placa T Daath (Chack only ona) Hospital: 2 No Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? funeral 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Tyas 2 No Invastigation after death. 2 Accidant Director: / 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) n 24 hours after on Funeral Director 4 ☐ Homicida Hospital 29a. Cartifiar 12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. edicai pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the I within 2 To the I 29d. Data signed (Month, Day, Year) 29c. Licansa number 022780 tated ceusa of daath (Itam 23a) (Type, Print) MD 4500 Green way Ctr. Dr. Stey 30 Greenbelt, Md 20770

32. Registrar's Sign

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Mc

199 1 0 199 July 1 1991

State of Maryland / Department of Health and Mental Hygiene

98 1274

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filed within 72 hours efter death with the Maryland thygiana. ther than "natural", or items 23a or 28a-f show ont, tra Med cal Examiner must be notified	Funeral Director	6012 Purdu	n Dr					207	18				.S.A.	vid y r
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of H of H fiter		20a. Mathod of Disposition 1 X Burial 2 ☐ Cramatic	n 3 □Bam	oval from St	0.0	ace of Dispo matary, crar	natory or ot	a of thar plac	ca)		Date	20c. Loce	tion - City or To	own, State
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Depertment of Heelth end Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28af show any injury or other traumatic event, the Madical Examiner must be notified at once.		4 Donation 5 Othai		iovar iroini bi		est :	Hills	5		4/	6/98	Clin	ton, Md	
Depent Import any inj		21. Signature of Funeral Sarv	ica Licensaa		7	22	2. Nama and	d Addra	ss of Facilit	у Нс	daes	and 1	Edward	s
205 2 2		22. Nama and Addrass of Facility Hodges and Edward 3910 Silver Hill RD. Suitland, More and Edward 3910 Silver Hill RD.												
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		30. Nama and address of pers	on who	lated cause	of death /lear /	23a) /T	Drint\	3			Rd. (1178	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 12:10gm 4b. City, Town, or Location of Deeth Joseph Morgan 4e. Fecility Nama (If not institution, give street end number) 40. County of Deeth tospital Hundar 1 Yaar Mashington Wine 8. Data of Bidh (Month, Day, Year) 3/11/26 9. Birth Con Solution Washington OY If Undar 24 Hrs. 9. Birthplaca (State Foreign Country) S. C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Deys Hours Months 1 M 2 F 248-30-0206 Usuel Residance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Tyras 2 □ No P.G. Ft. Washington, MD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20744 U.S.A. 8900 Lynalan Dr. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yes, Giva X Yeer or Datas: 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3 □ Widowad 4 □ Divorcad 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondery (0-12) 1 2 Coilega (1-4or 5+) Brick Layer Private 17. Father's Name (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maidan Sumama) Ivory Cleary Robert Morgan 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8900 Lynalan Dr. Ft. Washington, Md. 20744 Rose Hicks 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, crematory or other piece) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata Forest Hills Cemetery 4/6/98 Clinton, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funarel Sarvice Licensee 22. Nama and Addrass of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland,Md.20746 ELLEL 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrast, Approximata Intarvei Between Onset and Deeth Immediata Causa (Final anterior wall disease or condition resulting in death) 91200 nuyo cardial 3mg audim ers Dua to (or as a consequance of): Severa atteros dastic compry teat Jears Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Candio sayo pathu ; Dua to for es e consequenca of): Jears Ethanolia STORMOW GOL carcenones of Right Years 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cadexia PACCOM ONICO Dalydrahm 24b. Wara autopsy findings evellable prior to completion of cause of death? 24a. Was en autopsy performed? sonile bementa Alzheimon's Type 1 Yes 2 No 1 ☐ Yes 2 ☐ No Resipheral asterias edisappo SPORIO disquee 26. Placa of Death (Check only ona) Hospital: 1 √Inpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28a. Data of injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No

Examiner ettending physician and for use as the buriel-transit P.O. Box 68760. signed by the Records, 90 has page 2 certificate Division of Vital the Hospital or Attending Physician: nin 24 hours after deeth. director, funeral After To the Hospital or Attendir within 24 hours after deeth.

To the Funeral Director: At completely filled in by the fu

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumetic event, the Medical Examines must be notified at

Joseph

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Completed 25. Was case rafarred to medical axaminar? Be 1 Yas 2 No 2 27. Manpar of Death Medical Certification: 1 Natural 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

to Certifying Physician: To the best of my knowladga, daath occurred et the tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and piace, and dua to the cause(s) end mannar stated. 29b. Signature end title of certifier

29a. Cartifiar

29c. License number

29d. Date signed (Month, Dev. Year)

30. Nama and Iddrass of person who complated causa of death (Itam 23a) (Type, Print)

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state 101.

7900 old Branch ava 14.10

Clinton, Maryland 20135

State Registrar 31. Data filed (Month, Day, Year) 32. Registrar's Signatura APR 07 1998

State of Maryland / Department of Health and Mental Hygiene

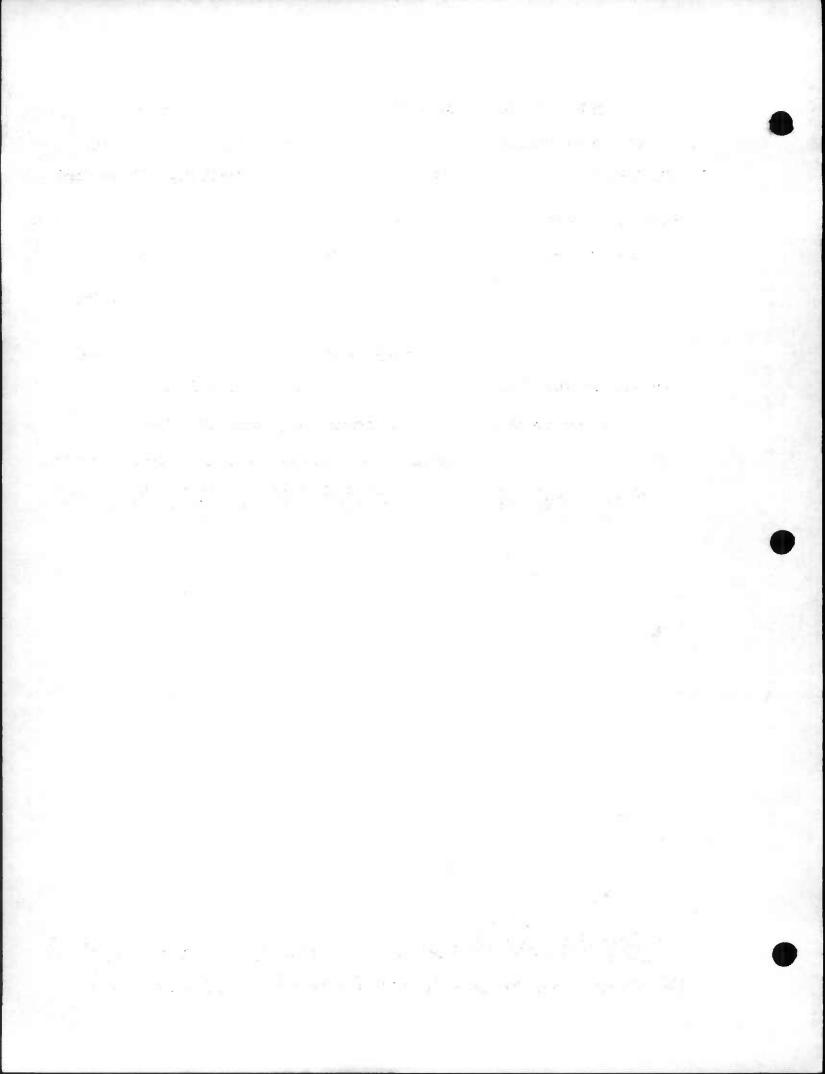
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** MARY CATHARINE McCOMMONS April 2, 1998 /Medical 5:30 AM 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Rock Spring Village Forest Hill Harford If Under 24 Hrs.
Hours Min.

8. Dete of Birth (Month, Dey, Year)
April 21, 1923 Maryland If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys Months Yrs 74 Director 215-12-6540 Usual Residence of Decedent 72 hours after death with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flama 23a or 28a-f ahow treumstic event, the Medical Examiner must be notified at Directo Maryland Harford 1 ☐ Yes 2 ☐ No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 506 Magnolia Road 21085 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: White þ Specify: 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Civil Service 17. Fether's Neme (First, Middle, Last) parmit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: if item ZT is marked oth
any injury or other treumatic event 18. Mother's Name (First Middle Maiden Surneme) Be Richard Brinsley Sheridan Ella Jane McKinstry 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) R. Bruce McCommons/Son 237 Garnett Road, Joppa, MD 21085 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury Methodist Cem. 4/4/98 Abingdon, Maryland 21. Signeture Funerel Service Licensee 22 Name and Address of Fecility Howard K. McComas III Funeral Home, P.A. 23a. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.

1317 Cokesbury Road, Abingdon, Maryland 21009

Approximate Intervel Between Onset end Deeth Physician immediate Ceuse (Finel disease or condition resulting in death) /Medical ACUTE MYOCARDIAL hour Examiner oronary Vascular Disease Physician/Medical Examiner attending physician and for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760. that initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? the Yss been signed by pertension COPD, 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24e. Wes en autopsy performed? Perpheral Vascular disease certificate has 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes case referred to medical ASSISTED 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospitel: s after death.
I Director: After this coord in by the funeral dire P 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: 27 Menner of Deeth 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

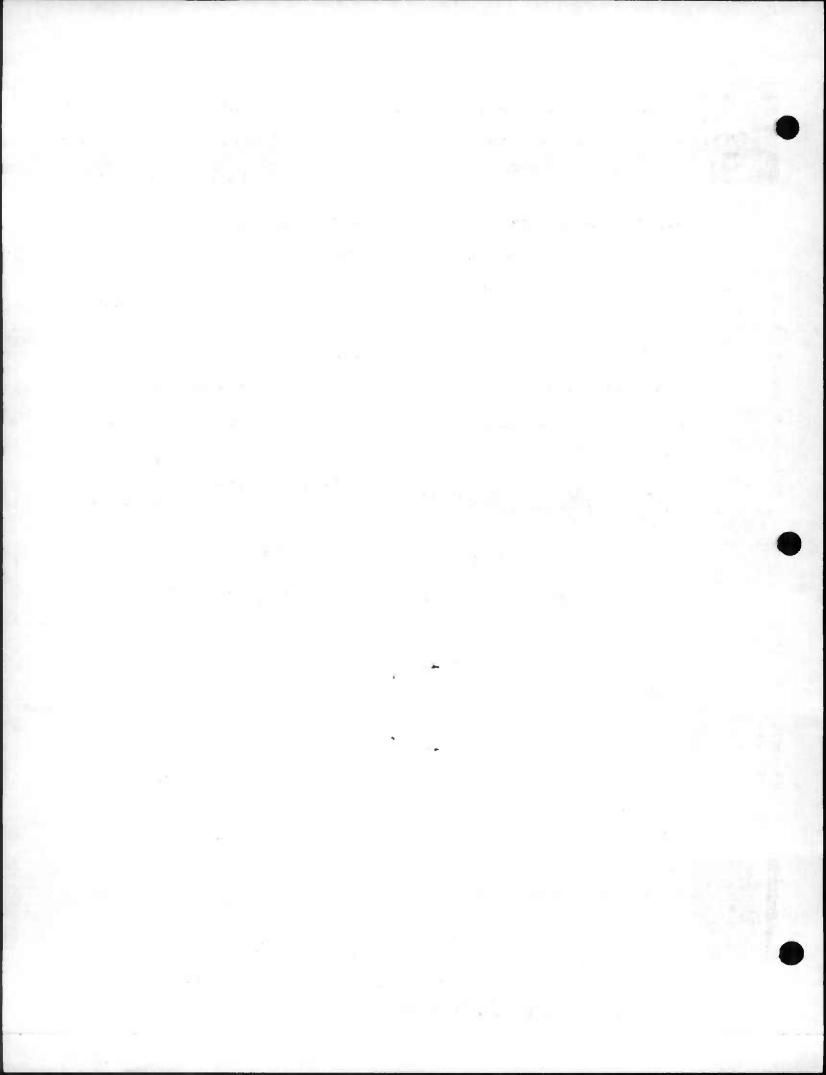
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e, Certifier Medical 29b. Sig 29c. License number 29d. Dete signed (Month, Day, Year) 1069 siness Center Way #102 Edgewood 31. Dete filed (Month, Dey. 82. Registrer's Signeture State APR 3 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Month April 9, 1998 Mabel Roberta Spicer Neild 5:15 am /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Glasgow Nursing Home Cambridge Dorchester If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
May 31, 1909 If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Days 1□ M 2♥ F Yrs. Director 214-74-3101 88 Maryland Usual Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. tnside City Llmits 7 is marked other than "natural", or itsms 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Taylors Island Maryland Dorchester 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Bay Shore Rd. 21669 U.S.A. Funeral 12. Was Dacedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: 11 Maritel Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or fran any Injury or other traumatic event 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Theophilis Travers Spicer Adeline Griffith 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John S. Neild, Jr./Son 5110 North Dr., Cambridge, MD 21613 20b. Plece of Disposition (Name of cematary, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4-13 Taylors Island, MD Grace Episc. Ch. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Curran-Bromwell Funeral Home, P.A. WWWW 308 High St., Cambridge, MD 21613 308 High St., Cambridge, secondinate caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and one could one can be one each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner anni inposm des bunel-transit Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physician s the buriel Box 68760 Physician/Medical Dua to (or as a consequenca of): CUD ettending P.0. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yss 2 ☐ No 3€ Probably 4 Unknown signed I Division of Vital Records, þ 24e. Was an autopsy parformed? 24b. Were eutopsy findings available prior to Completed peen completion of causa of deeth? page 2 2 No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nureing Home 5 Residence 6 Other (Specify) 1 Yes 20 No. P 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, date end placa, and dua to the ceuse(s) and menner stated. 29a, Certifier 29b. Signature end title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D0050987 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Street Combinage mo 21613. Aurora 105 Wawa3 32. Registrar's Signature 31. Date filed (Month, Day, Yaar) State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Month Year 04 OMIDALE OMIBISHAL 88 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth SINAI HOSPITAL BALTIMORE If Under 1 Yaer | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Yeer) APRIL 22,1923 9. Birthplece (Stete or Foraign Country) RAN 7. Aga (In yrs. lest birthday) Days Hours 1☑M 2□F Yrs 220-43-6320 74 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X□ Yes 2□ No HOWARD ELLICOT CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7807 OLD HOLLOW LANE 21043 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Navar Married 2X Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: IRANIAN 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) MECHANIC 8 PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) RAZI OMIDISHAL **BAHAR** 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) GHOLAM ABBAS OMIDISHAL / SON 7807 OLD HOLLOW LANE ELLICOT CITY MD 21043 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dafe ty Burial 2 ☐ Cremation 3 ☑ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) TEHRAN CEMETERY 4-14-98 TEHRAN IRAN 22. Name and Address of Facility POPE FUNERAL HOME of Funeral Service Licensae 2617 PENN. AVE S.E. WASHINGTON DC 20020 23a. Pert. Enter the disease, or complications that caused the daarh. Do not enter the mode of dying, such as cardiac or respirefory errest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final · CARDIOGENIC MYDIARDIAL INFRICTION disaese or condition rasulting in death) Due to (or es e consequence of) CORONARY LEWKHOWN 32×3210 ARREZZY Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabeter 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Lunpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1🕰 CertifyIng Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner stated. 29b. Signeture end title 29c. License number 29d. Date signed (Month, Dey, Year) 036373 30. Neme end eddr completed ceuse of deeth (Item 23e) (Type, Print)

3449 Wilkew Ave #300

State Registrar

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/Medical

Examiner

Funeral

Director

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P.O. Box 68760,

Division of Vital Records.

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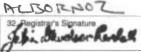
Baltimore, Maryland 21215-0020

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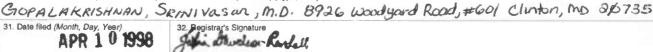
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BARBARA, A. ORTMAN 10.01 PM APRIL /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SOUTHERN CLINTON MARYLAND HOSPITAL PRINCE GEORGE'S If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20XF Months Days 577-34-3616 Yrs Director August 6,1928 Washington, D.C. Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, ins Mooical Examinar invaling notified at Maryland Anne Arundel Crofton 1 ☐ Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1717 Gunwood Place U.S.A. 21114 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 🗓 No P 3 ☑ Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 el Hygiene. Library of Congress Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Office Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fi h end Mentel F Is marked ott Eugene Collins Josephine Bonevaries 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 sh Depertment of Health end Important: If item 27 is m any injury or other traum once. Patrick C. Ortman/Son 2895 Willow Wood Ct., Crofton, Maryland 21114 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20c. Location - City or Town, Stete Date Metropolitan Crematory 4/9/98 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home lle 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) EDEMA PULMONARY Examiner 1 WK Due to (or as a consequenca of) Examiner CARDIDMYOPATHY 6 MONTHS physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, YEARS CORONARY + VALVULAR HEART DISEASE Physician/Medical Due to (or as e consequença of P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown ANEMIA, CIRRHOSIS, FAILURE, Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy URDSEPSIS 1 Yes 2 No 1 TYes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth Certification: 28c. Injury at Work? 28d. Describe how injury occurred Director: After t i or Attending Patter death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direction please of the Funeral Direction of the Funeral Direct 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number L. Crinibasan, MD APRIL, 07, 1998 D 46345

State Registrar

31. Date filed (Month, Day, Yeer)
APR 1 0 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



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		State of IV	laryland / De C	ertificate of			Reg. No.	12747
Physician	Decedant's Nama (First, Middla, La CLARENCE HANNIE					2. Data of Da Month 4	Day	98 3. Time of Death 10:10 AM
/Medical Examiner	4a Facility Nama (If not institution, git MARINER HEALTH CA	va street and number	ין		4b. City, Town, or KENSINGT		MONTG	of Death
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Aaryland I show ed at	Usual Rasidanca of Dacadant 10a. State 10b. County MD. MONTGON	MERY	10c. City, Town or TAKOMA					10d. Insida City Limits Y 1 ☐ Yas 2 ☐ No
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permit. Pa Departmer Important: any Injury pace.	21. Signatur of Funaral Sarvice Lice	P. ma	rshall	22. Nama and Add 4217-9th		N.W. Wa	ashingto	on, D.C. 20011
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/Medical Examiner	Immediata Causa (Final disaase or condition resulting In death)	PNEUI	MONIA Due to (or es a con	sequance of):				6 days
whysician and the burist-transit dical Examiner	Saquantially list conditions, if any, leeding to immediate cause. Enter Undarlying Causa (Disaase or Injury	b	Dua to (or as a con	sequenca of):				
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The law requires the sate has been signed, page 2 should be d						24a. Wa: perf	s an autopsy ormad?	24b. Ware eutopsy findings availabla prior to complation of cause of death?
sician: The law is certificate has birector, page 2 s o Be Compile	25. Was casa refarred to medical				26 Place of D	1 Deeth (Check only	Yas 21 No	1 ☐ Yas 2 ☐ No
Phy this ral c	axaminar? 1	Hospitel: 1 Inpa 28a. Data of in (Month, L		a of 28c. In	Othar: 4½ Nursing	Homa 5□Ras		
To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completaly tilled in by the tuneral Medical Certification:	2 Accident invastigetic 3 Suicida 6 Could not l 4 Homicida datarmined		njury - At homa, farm, atc. (Specify)			28f. Location City or To	(Street and Num own, Stata)	ber or Rural Routa Number,
ne Hospita n 24 hours ne Funersi pletaly tille edical C	29a. Cartifiar 1 Certifying P	hysician: To the best miner: On the basis and mannar		aath occurred at the r Invastigation, In my	tima, deta and place opinion, deeth occ	e, and dua to the curred at the time	a cause(s) and m	pannar as steted. , and dua to tha ceusa(s)
To the comp	29b. Signatura and titla of certifiar	Shara	elm	1 -14 -14	nsa number 3944		29d. Data sign:	ad (Month, Day, Year) /98
(6)	30. Nama and addrass of person who 3720 Farragut A	//	death (Mam 23e) (Ty ensington,	1	95-2110			
State Registrar	31. Data filed (Month, Day, Year) APR 08 199		strar's Signatura					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) THUR SAMES Apric 1119 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, Carroll County General Hospital Carroll Westminster Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1X M 2□ F Yrs. 55 160-32-8878 Nov 15, 1942 Pennnsylvania Usual Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 3(T)No Maryland Carroll New Windsor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 3206 Hooper Rd. 21776 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 13 Yes 2 No 1961-If Yas, Give 1961-Year or Dates: 1960 1 Never Married 2 Married Specify: White 1 Yes 2X No Specify: 3 Widowed 4 Divorced 1969 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Manager Technical Publishing | MITRE Corporation 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Palmer Marion Dailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Paulette A. Palmer (wife) 3206 Hooper Rd. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lake View Memorial Park 4/10/98 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Directors, P.A. ellner 1212 W. Old Liberty Rd. Winfield, MD 21784 Part 1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) Due to (or as a consequenca of) NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other treumstic event, the Medical Express.

Physician/Medical Examiner ettending physician end for use es the bunal-transit ed by the e þ bluods Completed hes certificate Be

The law requires that the death certificate be executed

the Hospital or Attending Physician;

death Director: A

To the Hospital C. within 24 hours effer de To the Funeral Direct

After this

Division of Vital Records, P.O. Box 68760,

2 Certification:

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manne of Death 1 Naturel 5 Pending Investigation 2 Accident

6 Could not be 3 ☐ Suicide 4 Homicide 29a. Certifier

31. Date filed (Month, Day, Year)

(Check only one)

1 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Specify)

2 ER/Outpetient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Routa Number, City or Town, State) Certifying Phyatcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred et the time, dete end pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hospital:

29c. License number 028221 29d. Date signed (Month, Day, Year)

ited cause of death (Item 23a) (Type, Print) (M)

200 Memorial Ave., Westminster, MD 21157 HOSPITAL courty benefice

State Registra

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Roscoe William Packard 04 04 1998 0117 /Medical 4a. Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Undar 1 Year Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MO **Funeral** 1 X M 2□ F Months Yrs Director 81 07/26/1916 267-10-1040 Usuai Residence of Deceden the Marylend show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director Yes 2□No MD Harford Havre de Grace 10e. Street and Number 10f. Zin Coda 10g. Citizan of What Country? USA 610 A Bourbon St Funeral 21078 filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritai Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Types 2 □ No If Yas, Giva Year or Dates: WW2 1 Never Marriad 2 Married "natural", or 1□ Yes 2♥ No þ 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) marked other than Coilege (1-4or 5+) Hygiena. 8th Carpenter Government Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Pages 1 end 2 should be 1 nent of Health and Mental I Edward William Packard Addie Mae Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 s Department of Health ar Important: If Item 27 is any injury or other trau Mildred E. Packard- Wife 610 A Bourbon St Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdns 04/8/98 Aberdeen, MD 21. Signature of Funeral Sarvice Licensae 22. Nama and Address of Facility Mitchell-Smith Funeral Home, P.A. Lamo & 123 S. Washington St. Havre de Grace, MD 23a. Part1. Enter the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner The law requires thet the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician Physician/Medicai Due to (or as a consequence of): for use as signed by the at d be detached for Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Unknown Records, S 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performad? Be Completed EXPROLYTE IN ROPANA has 1 Yes 2 No this cartificate 1 Yas 2 No Vital director, 25. Was cese referred to medical examiner? 26. Piace of Death (Check only ona) Hospitei: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 XNo of illed in by the funeral 28a. Data of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A affer 4 Homicide Hospital 24 hours 8 To the Hospital within 24 hours a To the Funeral Completaly filled Certifying Physician: To the best of my knowledge, deeth occurred at the tima, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of carette 29d. Date signed (Month Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1998

32. Registrar's Signeture

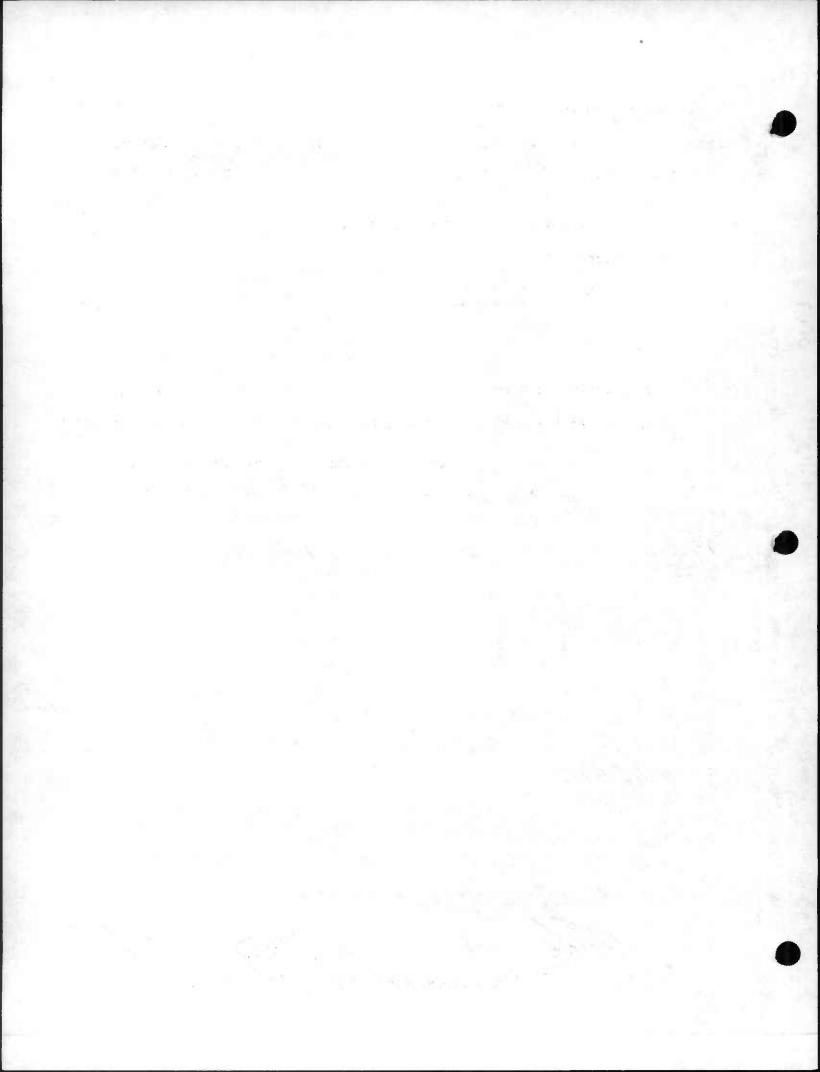
31. Date filed (Month, Day, Yaar)

APR 6

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death

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Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) JOHN

RICH

2. Date of Death Month MARCH

8. Date of Birth (Month, Dey,

31, 1998

21,1943

3. Time of Death 3:05 p.m

4a Facility Name (If not Institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Deeth

CHEVERLY

If Under 24 Hrs.

Hours

4c. County of Death PRINCE GEORGES

Funeral Director

death with the Maryland

filed within 72 hours after

other than

permit. Pages 1 and 2 should be file Department of Haalth and Mental by Important: If frem 27 is marked oth any Injury or other traumatic avent once.

Physician

/Medical

Examiner

attending physician and for usa as the burial-transit

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24 hours

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The law requires that the death certificate be axecuted

Box 68760.

Division of Vital Records,

Physician:

Hospital or Attanding

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Examin

Physician/Medical

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Completed

Be

2

Certification:

Medical

r than "natural", or items 23s or 28s-f show the Medical Examiner name be notified at Directo Funeral P Completed

6. Sex. 1 AM 2 F 577-56-4831 Usual Residence of Decedent 10a. Stete 10b. County MD P.G.

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthdey)

CAPITOL HEIGHTS

If Under 1 Yeer | Months | Days

10d. Inside City Limits 1 XYes 2 No

WASH., DC

Birthplace (State or Foreign Country)

10e. Street and Number

10f. Zip Code

10g, Citizen of What Country? U.S.A.

4801 ADDISON ROAD

11. Merital Status 1K Never Married 2 ☐ Married 3 Widowed 4 Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

20743

14. Rece - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed)

College (1-4or 5+)

E.

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondary (0-12) 12th

17. Father's Name (First, Middle, Last)

ASSISTANT

DISPATCHER 18. Mother's Name (First, Middle, Melden Sumeme)

N/A

CARL

RICH

ETHEL

FUNERAL

1722 NORTH CAPITOL ST.,

SIMS

NW WASH.DC 20001

19a. Informant's Name/Relationship (Type, Print)

5906 CLEVELAND AVE., RIVERDALE, MD

19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20737

20a, Method of Disposition

1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State

FRANCES HOLLAND - SISTER

20b. Place of Disposition (Name of cemetery, cremetory or other place)

20c. Location - City or Town, State Date

HOME

Approximete Interval Between Onset end Deeth

4 ☐ Donation 5 ☐ Other (Specify)

HARMONY MEMORIAL PK 22. Name and Address of Fecili

7-1998 LANDOVER, MARYLAND

of Funeral Service Licenses Part1. Enter the disease, or complications to shock, or heart failure. List only one cause

ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Lung Cancer with Metastasis

Due to (or as a consequence of)

Cardiac Arrests Due to (or as a consequence of):

Sepsis

Due to (or as a consequence of)

Alcoholic Liver Cirrhosis

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury resulting in death) Last

Immediate Cause (Finel disease or condition resulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Seizure Disorder

23b. Did tobacco ues contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown

Etoh Abuse

24a. Was an autopsy performed? 1 Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 XNo

Thrombocytopenia

Hospital:

30. Numer and address of person who completed cause of death (Item 23a) (Type, Print)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

5 Pending investigation

6 Could not be determined

1X Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year)

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

2X) No

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

1 Naturel

2 Accident

4 Homicide

3 Sulcide

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

enter

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Dey, Yeer)

32 Pogistrar's Signature

DHMH 16 Rev 6/95

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of Ma	ai yiai i		ificate of	f Death	Werital my	Reg. No.	8 (12751		
			1. Decedant's Nama (First, Middla, La	st)					2. Data of D	eath		3. Time of Death		
	Physici /Medi		Theo	odore All	en S	Slavin			April	8, 1998	Yaer	10:47 AM		
	Examir		4a. Facility Nama (If not institution, giv	a street and number)				4b. City, Town, or			of Desth			
			Malcolm Grow Medi	cal Center	r			Camp Spi	rings	Princ	ce Geo	rge's		
	Funeral		Social Sacurity Number 6. S	D	a (In yrs.		If Undar 1 Yes Months Dey		8. Deta of Bi (Month, D	rth ay, Year) 4, 1923	9. Birthpla	ace (State or Foreign		
	Director		192-14-0493 Usual Rasidance of Decedant	XM 2LIF 75		Yrs.			March	4, 1923	Taren	fum, Pa.		
	and and		10a. Stata 10b. County		10c. City	y, Town or Loca	ation				10	d. Inside City Limits		
	Mary 1 sh	ō	Maryland Prince (George's	Sui	itland						1 TyYes 2 No		
	r 28s	Funeral Director	10e. Street and Number		-		10f. Zip Coda			10g. Citizan of N	What Countr	ry?		
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ary	shour M Mn umat	-	19a. Informant's Neme/Raiationship (19b. Mailing	Addrass (Stre	et and Number or F	tural Route Numb	er, City or Town,	Stata, Zip (Code)		
Σ	alth alth 27 la		Lois L. Slavin/Wi	fe		Same a	as item	10						
ore	of Ha		20a. Mathod of Disposition	D	20b. P	lace of Disposit	tion (Nama of tory or other p	lace)	Data	20c. Location -	City or Tow	m, State		
Ē	Pag nent ant: H		1 Donation 5 Other (Specific					metery 4	/11/98	Clinton	, Mar	yland		
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show says injury or other traumatic event, the Medical Examines must be notified at once.	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility George P. Kalas Funeral Home												
ш	205 2 2		6160 Oxon Hill Rd. Oxon Hill, Md. 20745 230 Part. Enter the disease, or composition that caused tha death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Apr											
		- 2	234. Part. Enter the disease, or com- prock, or heart failure. List only	that caused	tha daath	. Do not enter	the mode of d	ying, such as cerdia	c or raspiretory	arrest,		Approximata Intarvsi Between		
	Physician			0								Onsat and Death		
	/Medical Examiner		Immediata Causa (Final disassa or condition rasulting in death)	Sudden (Cardi	Lac Deat	th				U	nknown		
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300	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M		d						İ				
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			OF Man ages referred to made at							Yas 2 No	10	Yas 2□ No		
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ō	tal or A rs aftar al Direction by	Certification:		Donoing, atc	. (opeuly	,			0.1,7 0.70	, σ.α.α./				
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	(m)		W mm	100			OK 3		DEDTME	April (الا, الار	98		
			30. Nama and address of person who of Darwin Childs, Ma			23a) (Type, Pr		G/1050 W REWS AIR			762-6	600		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						epartment of I			Reg. No.		752
	Physici /Medic		Decedent's Nema (First, Middla, SOLOMON D.	STROMAN				2. Data of De Month April	Day 2. 19	Yeer	ima of Death
	Examir Funeral Director	ner	240-46-5206	HOSPITAL	(In yrs. last birth	day) If Undar 1 Year		MARYLAND 8. Data of Bir (Month, Da	PRINCE th y, Year)		Stata or Foreig
	Meryland f show	or	Usuei Rasidance of Dacedant 10a. Stata 10b. County D.C.		10c. City, Town					10d. In	sida City Limits ☑ Yas 2☐ No
	th with the 23a or 28a ust be notif	al Director	10e. Street end Number 628 PICKFORD PLACE	N.E.		10f. Zip Coda 20002			10g. Citizen of V	What Country?	
200	in 72 hours eftar deeth with the Meryland "natural", or items 23a or 28a-f show logical Examinat must be notified at	by Funeral	11. Maritel Status 1 □ Naver Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Yeer or Datas:		13. Was Decedant of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	en, Maxican, Puarto	ecify Yas or No Rican, etc.)	- 14. Rac	ce - American Inc ck, White, etc.	ian,
	within ane. than	Completed	15. Decedent's (Spacity only highast s Elamantary/Secondary (0-12) 12th grade			ecedant's Usual Occup Give kind of work done fe. DO NOT usa ratire Truck Driv	during most of workind)	ing		usinass/Industry	
) idina	₽ d ie P	To Be Co	17. Father's Nama (First, Middla, La CHARLIE STROMAN, SF				18. Mother's Name	NEY	Maidan Suman	na)	
S S	1 and 2 s Health er em 27 is ther trau		19e. Informant's Name/Relationship FANNIE M. STROMAN (20a. Mathod of Disposition 1\(\tilde{\tilde	WIFE) □Ramoval from Stata	628 20b. Place of D cematary,	Mailing Addrass (Street PICKFORD PLA Disposition (Nama of crematory or other pla Memorial Par	CE, N.E. W		D.C. 2		tete
	permit. Pages Depertment of i importent: if its eny injury or o once.		21. Signature of Funeral Sarvice Lic		lier	22. Nama end Addre 4339 HUNT PL	ass of Facility ROLL	INS FUNE	RAL HOME,	INC.	N
	Geath certificets be executed Medical e ettending physician and d for use as the butal-transit	an/Medical Examiner	23a. Part1. Enter the disease, or shock, or heert failurg. List on immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	a Acute b Corona c Diabet	Myocar Dua to (or as a co	dial Infansequence of): ery Diseansequenca of):	rction_			Onse	at and Death
	that the deal led by the ett detached fo	Physician/M	Part II. Other algnificant conditions COPONARY 8	-			van in Part I.		tobacco usa co	ntributa to the o	
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	Physician: The law this certificate has brial director, paga 2 s	Be Completed	25. Was casa referred to medical axaminar?	Hospital:		Ott	28. Pleca of Death	(Chack only o		1 □ Yas	2 🔯 No
	Attending ar death. ector: After by tha fune	Certification: To	27. Mannar of Deeth 1 Notural 2 Accident 3 Suiclda 4 Homlcida	28a. Date of Injury (Month, Day	Year) Inju	na of 28c. Inju	ry at rk?	28d. Describe I	now Injury occur		a Number,
	Hospita 4 hours Funeral tely fille	edical	(Check only 2 Medical Example)	Physician: To the best of aminar: On the basis of a and mannar state	exemination and/	or invastigation, in my o	opinion, deeth occurre	and dua to tha ed at the time,	dete end place,	and dua to tha c	
1	To the To the Comple	2	29b. Signature end title of certifier	0.5	200		se number	(md)	29d. Date signe	(Month, Dey, 1	'ear)
(Sta	ite	30. Nama and address of person where Lynne Diggs 31. Date filed (Month, Day, Yaar) APR 06	MD 32 Registrar		70 Bladen	sburg Ro	i, NE	Wash.,	DC 20	018

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month 4b. City, Town, or Location of D 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Takoma Park
if Under 24 Hrs. 8. D
Hours Min. 0 Washington Adventist Hospital Montgomery 5. Sociel Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 1□M 2\ F Days Yrs. 234-48-0438 64 Dec. 22, 1933 West Virginia Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Marvland Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3574 Powder Mill Road 20705 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 11. Maritai Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementery/Secondery (0-12) College (1-4or 5+) 12 Bookkeeper Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henley Chaplin Diamond Addie Lucille Rutherford 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Smith - Husband 3574 Powder Mill Road, Beltsville, Maryland 20705 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 4/7/98 Adelphi, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Onset end Death Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24a. Was en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be P

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "netural", or items 23e or 28e-1 show any injury or other thatmatic event, the Medical Examine from the northed any injury or other thatmatic event, the Medical Examine from the northed as

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records. P.O.

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Medical

Examiner burial-transit and physician s the burial Physician/Medical use datached for the been signed by should be datac þ paga 2

1 Yes

27. Mapner of Death

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

2 00

5 Pending

Investigation

6 Could not be determined

Completed Be 2 Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica pletely

State Registrar

Pert II. Other significant conditions contributing to death but not restricting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Dete filed (Month, Day, Year) 07

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 02:18 PM **Physician** APRIL STEPNEY 1998 FRED N. 04 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner PRINCE GEORGES BRIGHT #101 GLEN ARDEN SENT ROAD 3016 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 5. Sociel Security Number 6 Sev **Funeral** 100 M 2□ F Months Devs Hours Director 428-16-0598 04-26-20 Mississisoi permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Maniel Hygiane. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Example Institute Institute. 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County Maryland Prince George's Lanham NEYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3016 Brightseat Road, #101 20706 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Black ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Truck Driver Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Charlie Stepney Rachael Alexander 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Harriett Stepney/Daughter 3016 Brightseat Road, #101, Lanham, Maryland 20706 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State Maryland Veteran's Cem. 4/10/98 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility J. B. Jenkins Funeral Home Percan Nan 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate
Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical * AFTERIOSCUEROTIC CARDIOVASCULAR DISTASE Examiner Due to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ettanding p signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown SLZHOIMER'S PICEASE à 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of death? certificata has b 1□ Yes 2 No 1 ☐ Yes 2 ☐ No ai or Attending Physician: The saftar death.
If Director: Attar this certificated in by the funerei director, pa 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Dete of Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical yletely (Check only one) 24 end menner stati To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29b. Signiture and title of certified 29c. License number DME

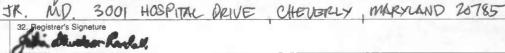
Registrar

31. Dete fited (Month, Dey, Year) APR 08

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d address of person who or

MARIO F.



cause of wath (ttem 23e) (Type, Print)

APPIL 04, 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** March 28, 1998 Robert Earl Scott 10:00 AM /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year, NOV. 12, 1922 9. Birthplace (State or Foreign **Funeral** 1□XM 2□ F Days Hours 457-26-0648 75 Dallas, Texas Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Yes 2□ No Maryland Prince George's Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20747 1432 Shady Glen Drive United States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1943/46
18) Yes 2 □ No 1951/6
If Yes, Give Yeer or Detes: 11. Marital Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be flied within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Med call Engine 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1951/82 1□ Yes 2⊠ No Specify: by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Architect AirForce Reserve 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Emerson Charles Scott Helen Mitchell 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lorraine T. Scott (Wife) 1432 Shady Glen Drive Forestville, Maryland 20747 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 4/14/98 20a. Method of Disposition 1 D'Burlal 2 ☐ Cremetion 3 ☐ Removel from State Arlington National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Arlington, Virginia two of Funeral Service Licen 22. Name end Address of Fecility Latney's Funeral Home, Inc. Lomon ueu 3831 Georgia Avenue, NW Washington, DC 20011 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset and Deeth Physician /Medical Immediete Cause (Final 2 week disease or condition resulting in death) Examiner Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown alasp Records. þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? page 2 certificate 1 Yes Division of Vital lal or Attending Physician: The safer death.

In Director: After this certificated in by the funeral director, po Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours tiscertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

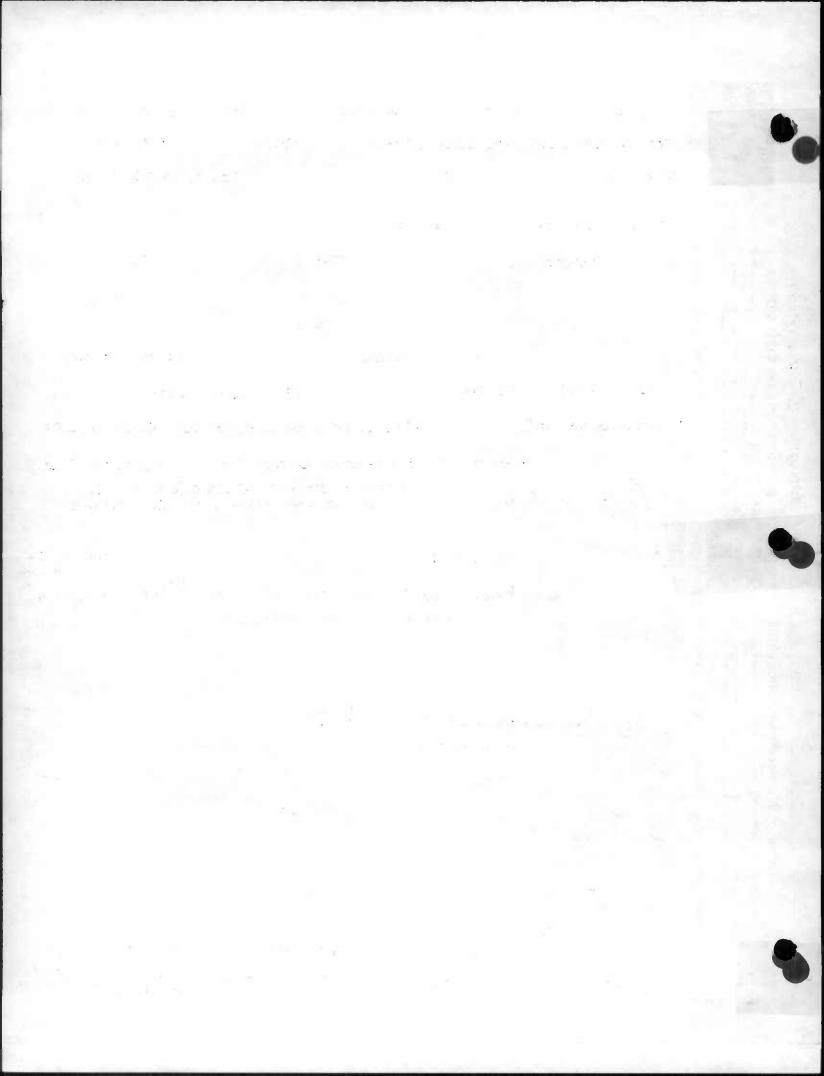
| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end menner stated. edical 29a, Certifier To the Hosp within 24 hou To the Funer completely fil (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) dune las March 28,1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. A. Mendhiratta C/O Kaiser HC 1500 Forest Glen Rd. Silver Spring, MD 31. Dete filed (Month, Day, Yeer) 32. Aegistrar's Signeture State APR 09 1990 Registrar

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Schafran DRIL Douglas /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, giva streat end numbar) Examiner HARFORD Lorien Nursing & Rehabilitation Center Belcamp
If Under 24 Hrs. If Under 1 Yaar Months Days Birthplece (Steta or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dev. Yaer) **Funeral** t M 2□ F Hours Min. Director 244-44-6567 Jan. 5, 1935 New York Usual Rasidance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23s or the Medical Examiner must be a Funeral 220 East Belcrest Rd. USA 21014 12. Was Decedant Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Status 1 Yes 22 No If Yes, Give Yeer or Detas: Jouglas B Schaffan 1 Never Merried 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) should be filed with nd Mental Hyglene. Public Education Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harry Schafran (nmn) Brown Lily Mae 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) artment of Health ortant: If Item 27 P. Ann Schafran/ Wife 220 East Belcrest Road, Bel Air Maryland 21014 of Disposition (Name of Dete 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 🔊 Other (Specify) Entomoment Bel Air Memorial Gardens 4-10-98 Bel Air, Maryland 22. Name end Address of Fecility
Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland
23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximately a shock, or heart failure. List only one under on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final diseese or condition resulting in death) COMX Examiner Due to (or es e consequence of): Examiner Brain Tumor Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Diseese or injury that initiated evants resulting in deeth) Lest physician the burla Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 8 985 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Dependent 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Mellitus page 2 1 Yes 2 No 1 Yes 2 No confilicate 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of Certification: 5 Pending investigation 1 Neturel 2 No 1 Yes 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide alte b 24 hours Puneral edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. (Check only one) Within 2 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and title of cartifile 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 210101 AZAT berdeen MANUEL 32 Registrer's Signature 31. Dete filed (Month, Day, Year) 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amended # 20b. P.G. G.C. 4/13/98 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer 7:49 AM JAMES THOMAS SMITH, April 7, 1998 /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery

9. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) 6. Sex 1 M 2 □ F **Funeral** Hours Months Deys Yrs. Director 578-42-6110 Sept. 10,1933 Washington, D.C Usual Rasidence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at 10d. Inside City Limits D.C. N/A Washington 1 No 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? With 4530 Ft. Totten Drive, N.E. death 20011 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 No No Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or then any Injury or other traumetic event, the Mastical Exerctions. 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0020 If Yas, Give Yeer or Detes: 1951/54 1 ☐ Yas 2 ☒ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Benefits Supervisor U.S. Government 12th 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be James T. Smith, Sr. Mary M. Dent 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Yvonne Smith - Wife 40 Hunter Gate Ct., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Neme of cametary, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 □XBuriei 2 □ Cremetion 3 □ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park Landover, MD 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Marshall's Funeral Home, Inc. 23a. Fait. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approxime Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immediate Ceuse (Finel PULMONARY EMBOLISM disease or condition rasulting in deeth) Examiner Examiner COROMARY ARTERY DISEASE the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequença ot) pue Box 68760. PERIPHERAL MSCULAR DISEASE Physician/Medical Due to (or es e consequenca ot): RIGHT F007 GANGRENE Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS þ 24b. Were autopsy findings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy Completed peen UPPER GASTROINTESTIMAL HEMORRHAGE 1 ☐ Yes 2 XNo certificata 1 ☐ Yes 2 ☐ No Mospital or Attending Physician:
 24 hours after death.
 Funerel Director: After this certifica 25. Was case rafarred to madical axeminer? Be 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yas 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner ot Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 5 Panding invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, tactory, offica building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, daath occurred et the tima, data end placa, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted. 29a. Cartifie Medical plately (Check only one) To the within 2 29b. Signature and little of portition 29c. License number 1)-14400 30. Name and address of person who completed causa of deeth (Item 23e) (Type, Print) 831 UNIVERSITY BLVB. #21 SILVER SPRING ERNESTO AFRICANO, M.D 32, Registrar's Signature 31. Date filed (Month, Dey, Yeer) APR 1 0 1998

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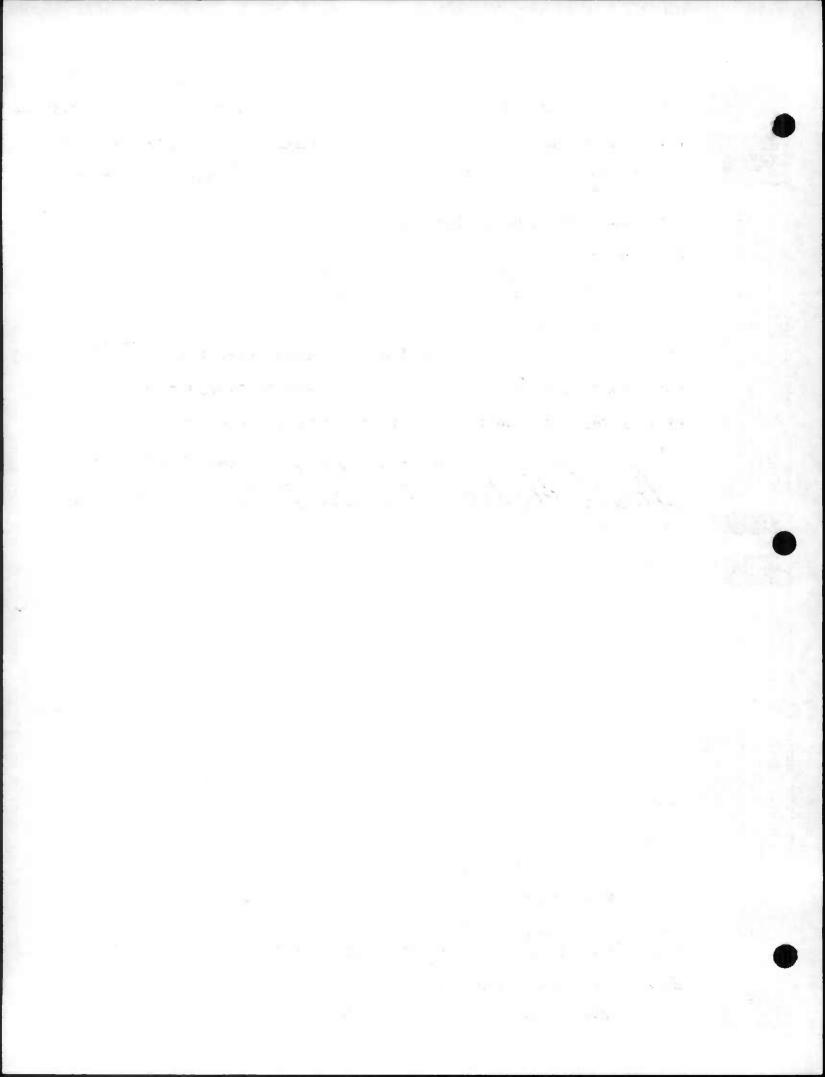
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-	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Undar 1 Yaar	If Undar 24 Hrs.			9. Birthplace (S Country)				
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0020	72 hours after death with the Meryland naturel; or items 23s or 28s-f show deal Examer must be noticed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ever i Armed Forces? 1 ☐ Yes 2(TNo If Yes, Give X Yaar or Datas:	1	Vas Decedent of P Yas, specify Cub □ Yas 2 ☑ No	lispanic Orlgin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No Rican, etc.)	Specify	a - Amarican Indi ok, Whita, atc. BLACK	an,			
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e, Maryland 21215-0020	and and		19a. Informant's Name/Reletionship (T)	pe, Print)	19b. Mallin	g Address (Street	and Number or Rui	al Route Numb	er, City or Town,	State, Zip Code)				
	E M N F		LUVENIA L. THOMI				REET, MT.							
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	amoval from State	* .	atory or other pla		Date		City or Town, Sta				
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Ba	Depa impo any i		22. Nama and Address of Furferal Service Mensee 22. Nama and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712											
			23a. Part1. Enter the disease, or compl shock, or heart feilure. List only or		leath. So not ente	r the mode of dyl	DE ISLAND	AVE., I	TI. KAIN		ZU/12 eximata al Between			
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٧	/Medicai Examiner	Н	timmediate Cause (Final disease or condition resulting in death) a. Metastatic Cancer Pue to (or as a consequence of): 4 month											
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of	£ 5 m	7: To	27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3□ DOA 311 28c. Injui	4 U Nursing Ho		dance 6 Oth how injury occur					
ion	Attending r death. ector: Afte by the fune	Certification:	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) tnjury		rk? Yes 2 □ No							
ivis	or Attenda Directo in by th	tific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, Stete)							er or Rural Route	Number,			
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	ro the rothin compl	Me	29b. Signature and title of cartifler	A		29c. Licens	se number		29d. Date signe	(Month, Day, Yo	ear)			
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10	(8)		39. Name and eddress of person who co	mpleted cause of death (Item 23a) (Type, F	Print)			, ,	111				
0	W	60	PATRICK CROSS	MD 106 I	rving .	ST. N.W	#220	b wa	Shington	1 D.C.	200/0			
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DHMH 16 Rav 6/95

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Al	MENDED	QAC	CHD 4/21/98 vri #1						lealth and Death	Mental Hy	giene 9	8	2759
	Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of De Month	eath Day	Yeer	3. Time of Death	
J	/Medi		John Thomas Tarr Jr.							Apri.			12:47 a
	Exami	ner	4a. Facility Name (If not institution, give		r)				4b. City, Town, o	r Location of Dear		inty of Death	
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	Funeral Director			M 20 F	ige (In yrs. ii 77	Yrs.	Months	Days	Hours Mi	n. (Month, D			place (State or Foreign intry)
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	ylanch how		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	a Ma	cto	Maryland Queen	Anne's	Que	ensto	wn						1 ☐ Yes 2Ã No
	or 28	Director	10e. Street and Number				10f. Zip (Code			10g. Citizen	of What Cou	intry?
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20	s afte	by F	1 Never Married 2 Married 3 Never Married 4 Divorced	1 Yes 2 if Yes, Give Year or Dates:	1943-	.45	☐ Yes 2	No No	Specify:			. 16	
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15	within 72 ane. than "nat	Completed	(Specify only highest grad	le completed)		(Give	kind of work	done retire	during most of w	orking	100. Killa 0		
212	yiane Tha	mo	1 2 Elementary/Secondary (0-12)	Coilege (1-4or		Offic	er f	or	Dept.	Correct	ion	Secu	rity
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/al	Vente	ToE	John Thomas Tar	r Sr.					Eva Ir	ene Smal mallwo o	l d Tar	r	
Baltimore, Maryland	and and a second		19a. informant's Name/Relationship (T)						t and Number or I		-		p Code)
	of Health them 27 r other tr	1 10	Dorothy May Par Ruth Irene Ford/D	ks Tarr					or Rd,	Queenst	own,	MD 3	21658
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	Examiner		disease or condition resulting in death)	· U	Jug	WD	ve	N	carl (allu			
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Box	eath certifi attending if for use as	Physician/Me		4 00	corc	ory	11 1	4	19001	Juc			
	0 9 2	sici	Part II. Other significant conditions con	ntributing to death	but not resul	ting in the un	derlying ca	use gi	very n Part I.	23b. Did	tobacco use	contribute t	to the cause of death?
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	5 B B	by											
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ō	Phys Phys	To	1 ☐ Yes 285-No	1 Li inpat	-	R/Outpatien		1		Home 5-BRes			ly)
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Division	I or Attending after death. Director: Atte d in by the fund	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Sin Diana of Ir	lione - At hone	na farm stor			Tes SC140	28f Location	(Street and No	imbar or Pili	ral Route Number,
5	2 - E	Fitia	4 ☐ Homicide determined	28e. Place of In building, e	ic (Specify)	ne, sam, sux	set, ractory,	omoe			wn, Stete)	moer or nur	ar noute Number,
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	P Hon 24 h Fur lately	edical	(Check only 2 Medical Examination)	nar: On the basis of	of examination	on and/or inv	estigation, i	in my	oplnion, death occ	curred at the time	date and place	e, and due t	to the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled	Me	29b. Signature end title of certifier		1 -		29c.	Licens	se number		29d. Date sig	ned (Month,	Day, Year)
			12mix le	m	6 N	11	7	3	048		4/1	6/08	3
			30. Name and address of person who co	omplieted cause of	death (item	23a) (Type, I	Print)					1 /0	
	diament.		ERIC F. CIGAM	/		TREVIL		OAT	CEN	TREVILLE	, MD	. 21	617
	Sta		31. Date filed (Month, Day, Year)		rar's Signati	ire	77 - 0 -		*				
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State of Maryland / Department of Health and Mental Hygiene

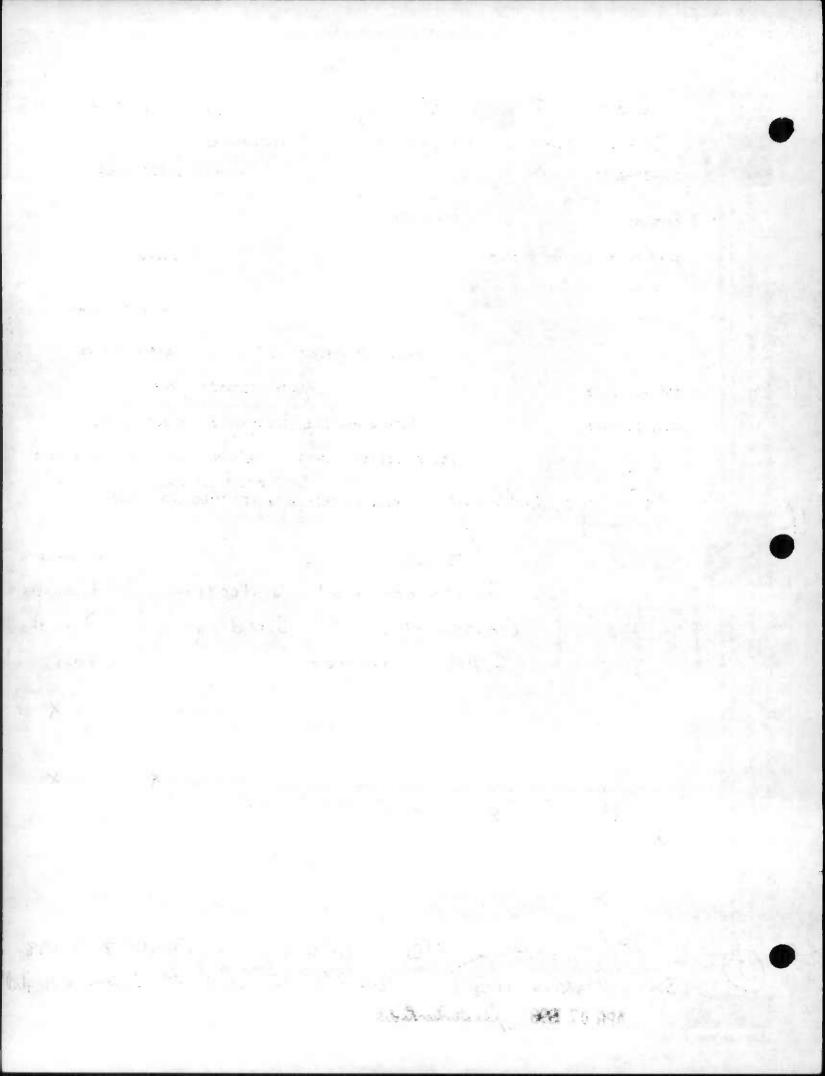
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, 1998 MARCH **JAMES** BRADEN TRADER, JR. 5:35PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER 5. Social Security Number # Under 1 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) DELAWARE **Funeral** 1 XM 2□ F Yrs. Director 220-26-8482 63 Usual Residence of Deceden the Maryland 10a Siate 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND DORCHESTER EAST NEW MARKET 10e. Sireet end Number 10f. Zip Code 10g. Citizen of Whai Couniry? 3907 JAY COURT 21631 USA Funeral 12. Was Decedeni Ever In U.S. Armed Forces? 1 ⊠Yes 2 □ No 1954 — If Yes, Give Year or Daies: 1956 11 Marital Steius Was Decedeni of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black. While, etc. 72 hours after 1 Never Married 2 X Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiena. Peges 1 end 2 should be filed within nent of Health end Mantel Hygiena. int: If Item 27 fs marked other than ' FINANCIAL Eiementary/Secondery (0-12) Coilege (1-4or 5+) MANAGER INSTITUTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) JAMES BRADEN TRADER, SR. MARGARET LEE GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health en Important: If item 27 is any injury or other trau CAROL A. TRADER/WIFE 3907 JAY COURT, EAST NEW MARKET, MD 21631 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 5 Other (Specify) 4 Donation MD EASTERN SHORE VET CEM 3/26/98 BEULAH, MARYLAND 22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Approximate intervel Between Onsei end Death Physician /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Examiner disease The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enler Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 98 ettending for use es P.0. Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 1 Yes 2 ANO 1 ☐ Yes 2 No Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, streel, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred ei the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) # 29b. Signeture end this of continue 29c. License number 29d. Dete signed (Month, Dey, Year) ann. 1005098 30. Name and address of person who completed cause of death (item 23a) (Type, Print) AHMED NAWAZ, M.D., 105 AURORA STREET, CAMBRIDGE, MARYLAND 21613 32. Registrer's Signature 31. Date filed (Month, Day, Year) State APR 0 9 1998 Registra

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Depenti Importu any Inj ance.	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility BERRY O. WADDY											
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APR 07 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 3, 1998 **Physician** MILDRED LEONE VARNER 12:30PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CLINTON, MARYLAND PRINCE GEORGES

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth

Months Days House Africa 8. Dete of Birth 6605 DANFORD DRIVE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country) **Funeral** Deys Hours 1□M 2X F 249-01-8044B 84 Yrs. Director JUNE 20, 1913 SC Usuel Residence of Decedent deeth with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 Ves 2 No Funeral Director MARYLAND PRINCE GEORGE'S CLINTON, MARYLAND 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 20735 U.S.A. 6605 DANFORD DRIVE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filled within 72 hours efter can end of Heelth and Mental Hygiene.
Int: If fem 27 is marked other than "natural", or iter
Inty or other traumatic avent, IT a Medical Experient 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE & GROCERY STORE OWNER PRIVATE/RETAIL 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be ELIAS COLLINS ELLA MURRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE GASKINS / DAUGHTER 6605 DANFORD DRIVE CLINTON, MARYLAND 20735 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, State 1 Buriai 2 □ Cremation 3 Permoval from State permit. Pege Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 4/8/98 SUMMERVITLE, S. CAROLINA PINELAND CEMETERY 22. Name and Address of Fecility ALEXANDER S. POPE FUNERAL HOME one of Funeral Service Licenses 5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747 Ins thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, cause on each line. Approximate Interval Between Onset end Death er the disease, or co heart failure. List on **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) ALZHEIDENS ~ 10 46202 DISTANT Examiner Due to (or es e consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificete be executed buriei-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medical the Due to (or as e consequence of): 88 for use signed by the et d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DE12WAR DISONDEN Division of Vital Records, þ 24e. Was an eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed MAZVNENIJIOV, DECUSIONS WLUINS TRAS INTECTIONS 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No RECENT WAINANY 25. Wes case referred to medical examiner? 8 26. Piece of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Naturel s efter death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical To the within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 1145607 Harry 30. Name end eddress of person who completed ceuse deeth (Item 23e) (Type, Print) P I Swint HAUGH MONITO (V) CHICCOM 503 8926 31. Dete filed (Month, Dey, Year) 32, Registrar's Signature State Shi Muslemka APR 08 195 Registrar

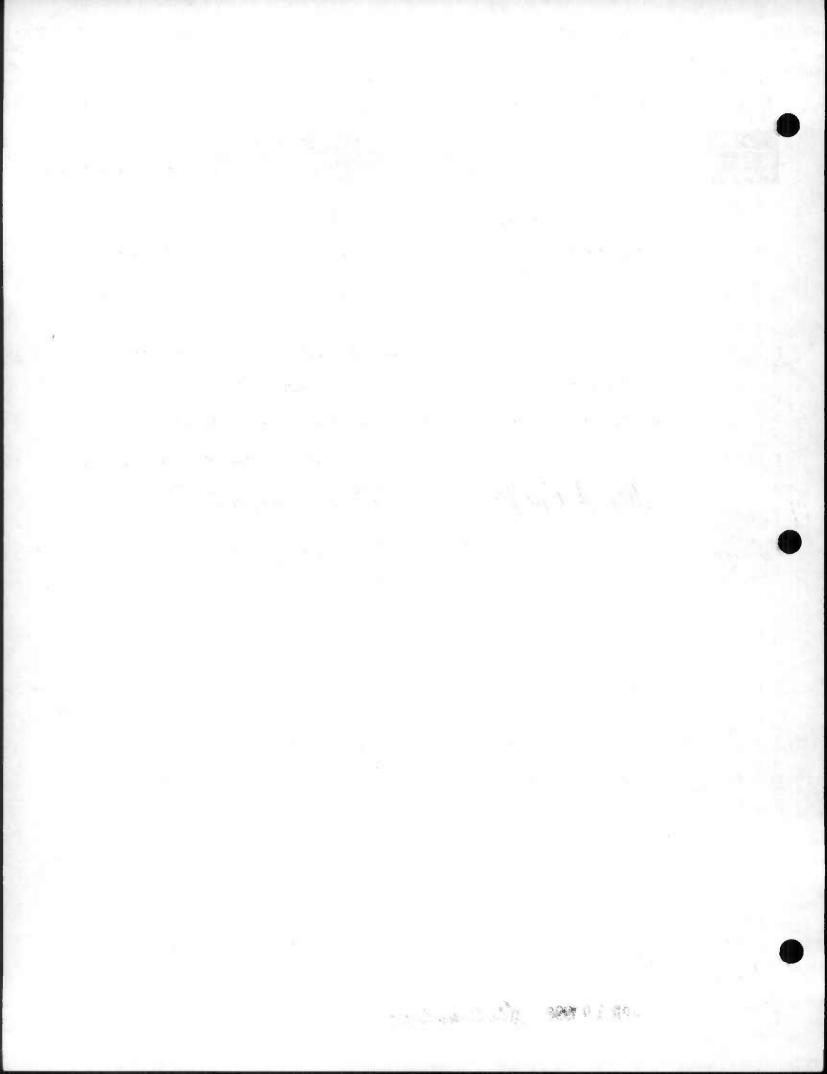
DHMH 16 Rev 6/95





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important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:	1 L Yes 2 L No Spe				o Hican, etc.)			eck, White, etc. ify: BLACK		
netra Police	Completed	15. Decedent's (Specify only highest of	15. Decedent's Education (Specify only highest grade completed)					16e. Decedent's Usuel Occupetion (Give kind of work done during most of work lifa. DO NOT usa retired)				usiness/In	dustry
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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certif	icate of	Death		Reg. No.	0 1	2/64
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Baltimore, M permit. Peges 1 end 2 Department of Health a important: if Itam 27 is any injury or other tra once.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				emetery		4/13/08	Landove	er Md	
Balti permit. Depentri Importa eny inju		21. Signature of Foreral Service Licen	500	Отеп	22. Na	me end Addre	ess of Facility F	razier's	Funeral	Home.	Inc.
m 88 5 8		100.	7				Island .			sh.,DC	
Physician /Medical Examiner		23a. Pert1. Enter the disease, or compshock, or heart feilura. List only of immediate Ceusa (Final disease or condition rasulting in death)	· Cara	dia	9	me		ac or respiretory	arrest,	0	proximete lerval Between nset end Death Bomint
	ē		Anna	Due to (or es	consequen	ca of):				>V	80.5
uted	Examiner	Sequentially that and disease	b. 788	Due to (or as e	2000	7				17	Cars
58760, icete be executed physician end s the burial-transit		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as e	Consequen	oe org.					
68760, ifficete be exe g physician eas the burial-	icai	that initiated events	c	Due to (or es a	consequence	oe of):					
x 68 entifice ling ph	Medicai	resulting in deeth) Lest									
IS, P.O. BOX as that the death cert igned by the attendin be datached for use	Physician/	Dati Official and the					1	Did tobacco use contribute to the cause of death?			
P.O.	hys	Pert II. Other significant conditions co	ontributing to death bu	it not resulting	in the under	lying ceuse gr	ven in Part I.				e cause of death? ly 4 □ Unknowr
S, F as that igned I	by P	Moderna	e mai	5.				-	108 200110	3 7 7 7 7 7	Ty 4 Diskilowi
cord v requir been s should	Completed	weight lo	88 Pe	g' Je	edi	ing			s en autopsy ormed?	availa	eutopsy findings bla prior to etion of cause
Vital Re- sician: The lav certificate has irector, page 2	E	De cartilan		γ		0		10	Van 21 N		_
	BeC	25. Wes case referred to medical					26 Place of De	eath (Check only	1 Yes 2 No		
Of Vital Re- Physician: The lav r this certificate has	To B	examinar? 1 ☐ Yes 2☑ No	Hospital:	nt 2 ☐ ER/0	utpatient 3	DOA Oth			Idenca 8 🗆 Oth	ar (Specify)	
On Of oling Physith. After this funeral di		27. Manner of Deeth 1 Naturai 5 Pending 2 Accident investigation	28e. Date of Injur (Month, Dey	Year) 28b.	Time of Injury	28c. Injui Woi			how injury occur		
Division or Attending R after death. Director: After In by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Pieca of inju bullding, etc	ry - At home, f . (Specify)	erm, street,	factory, office			(Street end Numb own, Stete)	er or Rural R	oute Number,
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of iner: On the basis of and menner stat	examination e	e, death occ nd/or invasti	urred at the tir	me, date and pled	ca, end due to the curred at the time	cause(s) end ma , date end pleca,	inner es state and due to the	d. a causa(s)
o the	0		wild mornior state			29c. Licens	se number	T	29d. Date signe	d (Month, Des	, Year)
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	Σ	29b. Signeture end trilla of certifier	'			0191	09		04-07.	98.	
(2)	2	> Jene:	ompleted cause of de	ath (Itam 23a)	(Type Print	2196			04.07.		
(3)	M	30. Nama and address of person who c		ath (Itam 23a)	(Type, Print	1	EET, M				

DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month 10:59 PM 4a. Fecility Name (If not institution, give street and number) /Medicai 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Birthplece (State or Foreign Country) **Funeral** Deys XXM 2 F 217-36-8506 57 Yrs Director 09-03-40 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Examiner must be notified at Maryland Prince George's Clinton Director 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9407 Paul Drive 20735 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, torces/ to yes 2 \sum No 9/63 If Yes, Give Yeer or Dates: 8/65 Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If flam 27 is marked other than any Injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 12th Shipping Manager Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) James E. White Sr. Lillian E. Tucker 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia V. White/Wife 9407 Paul Drive, Clinton, Maryland 20735 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veteran's Cem. 4/9/98 Cheltenham, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility J. B. Jenkins Funeral Home Nanc Kercen he 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** . Uncontrolled Gastro Intestinal Bleeding /Medical Immediete Ceuse (Finel diseese or condition resulting in death) Examiner Examiner End Stage Liver Disease -transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest pue the burial-Cerrhosis P.O. Box 68760, physician Physician/Medical Due to (or es e consequence of): as ettending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed page 2 s 1 ☐ Yes 2 ☐ No. Division of Vital Hospital or Attending Physician: 24 hours after death. Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical 29e. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) BN 5405/80

State Registrar 31. Dete filed

Daniele NUNEZ, 3261 Old Wash. Rd., #3010, Walderf,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			State of Maryland	Certificate of			eg. No.	12766	
	Physici /Medi		Decedent's Nama (First, Middla, Last) Richard Rodney Wool	ten		2. Data of Deat Month March 2	Day Yaa 29, 1998	3. Tima of Death 3:35 A.M.	
	Examir Funeral Director		4a. Facility Nama (If not institution, give street and number) 4403 Holmehurst Way West 5. Social Security Number 8. Sax 579-74-2265 7. Aga (In yrs. last		Bowie If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day,	4c. County of De Prince G Year) 9. 8 (20,1955 Wa	ath	
	Meryland f ehow	lor		own or Location				10d. Inside City Limits 1 ☐ Yas 2 ☐ No	
020	th with the 23a or 28a	Funeral Director	10e. Street and Number 4403 Holmehurst Way West	10f. Zip Coda 207	20		Og. Citizan of What (
	72 hours effer deeth with the Meryland naturel', or flerns 23a or 28a-f show deal Examiner must be notified at	by Fune	11. Marital Status 1 Nevar Married 2 Married 3 Widowed Divorced 12. Was Decedant Evar in U,S. Armad Forcas? 1 No If Yas, Giva Yaar or Datas:	13. Was Decedant of I- if Yas, specify Cub: 1 □ Yas 2 ▼ No	dispanic Origin? (Spean, Maxican, Puarto F Specify:	cify Yas or No- lican, atc.)	Black, Wh	narican Indian, nita, atc. n American	
Maryland 21215-0020	within 72 ho ena. than "natur he Medical	Completed	15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondery (0-12) College (1-4or 5+) 2 years		edant's Usual Occupation va kind of work dona during most of working . DO NOT usa retired) lassified Worker			s/Industry	
yland 2	ould be filed Mentel Hygi arked other atic event,	To Be Co	17. Fathar's Nama (First, Middla, Last) Junious Delfontia Wo	ooten	18. Mothar's Nama Edna	(First, Middla, N	Ma	ssey	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Merylan Department of Heelth and Mentel Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any Injury or other traumatic event, the Medical Examiner must be notified an once.		Francine Allen (sister) 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata		ginia Aven co) April 2, Cemetery ass of Facility Morr	Date N.E. 1998 S	;Apt.2;Wa 20c. Location - City of uitland, oodford,IN	shington, D. Cor Town, Stata	
	Physician /Medical Examiner	Iner	23a. Pant 1. Entar tha disaasa, or complications that causad tha death. I shock, or heart fallura. List only one cause on each line. Immediate Causa (Final disaasa or condition a. Hepatic Fail resulting in death)	Do not antar tha mode of dyle ure s a consaquanca of):				Approximate interval Batween Onsat and Death 1 month 1 month	
Box 68760,	eath certificate be asscuted attending physician and for use as the bunal-transit	an/Medical Examiner	if any, leading to immediate cause. Enter Underlying Metastatic Cause (Disease or Injury c.	o (or as a consequanca of): c Cancer of Pancreas 7 mont! (or as a consequance of):					
s, P.O. E	tha d y the	by Physician/M	Part ii. Other significant conditiona contributing to death but not rasulting	van in Part I.			te to the cause of death? Probably 4 Unknown		
Records	aw requin is been si 2 should	Completed t				24a. Was ar perform		wara autopsy findings available prior to completion of causa of death?	
Division of Vital F	Physician: The rthis certificate rail director, page	To Be	25. Was casa rafarred to medical axaminar? 1 \subseteq Yas 2 \subseteq Yas 2 \subseteq Yas 28a. Data of Injury 28	b. Tima of 28c. injur	y at 2	a 5 XRasida	AA	1 □ Yas 2 □ No	
Division	il or Attending Phaftar death. Director: After the in by the funeral	Certification:	1 ☑Natural 5 ☐ Panding 2 ☐ Accident Invastigation 3 ☐ Suicide 4 ☐ Homicide Could not be datarmined Could not be distarmined 28a. Place of Injury - At home building, atc. (Specify)	injury Wor M 1□	ork? □ Yas 2 □ No			Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director complately filled in	edicai	29a. Certifier (Check only one) 1	and/or investigation, in my o	pinion, daath occurre	d at the time, de	ete and piece, and d	ua to tha cause(s)	
);	Con Time of the or	M	29b Signatura and titla of certifier 30. Nama and address of person who completed causa of death (item 2)	29c. Licans D 23			April 1,		
	5/ Sta Registr	-	Martin D. Weltz, M.D7525 Greenway 31. Data filed (Month, Day, Year) APR 06 1998	Center Drive	s,Suite 20	5;Green	belt,Mary	land 20770	

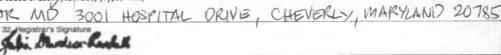
DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Deeth 3. Tima ot Death 1. Decedent's Nama (First, Middle, Last) Physician Physician 07:00 PM EULA MAE WILEY APRIL 02 1998 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street end number) Examiner PRINCE GEORGES KEPPLER TEMPLE HILLS 4605 PLACE If Under 1 Yeer | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthpleca (Steta or Foreign Country) **Funeral** Months Deys Hours Min 1 □ M 2√2 F 72 Yrs. 419-36-0859 Director 03 - 16 - 26Alabama Usuel Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete r than "natural", or items 23e or 28e-f show Temple Hills 1 Yes 2 No Prince George's Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20748 IISA 4605 keppler Place deeth v Funera 12. Was Dacedant Evar in U,S. Armed Forces? 13. Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. efter 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Never Married 2 Married 1 ☐ Yes 2 No Specify: **Black** g 3 Widowed 4 Divorced filed within 72 hours 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Domestic Worker Unknown ie marked other 17. Father's Name (First, Middle, Last) 18. Mother'e Neme (First, Middle, Maiden Sumame) Pages 1 end 2 should be nent of Health end Mental int: If Item 27 is marked or Pauline Scott Charley Wiley 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Andrews/Sister PO Box 126, Pinckard, Alabama 36371 20b. Plece of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition permit. Pages Department of Important: If it any injury or o 1 Buriel 2 Cremetion 3 Removel from Stete 4/11/98 landover, Maryland Harmony Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility J.B. Jenkins Funeral Home harles 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart teilura. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical · ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE diseese or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner certificate be assculed attending physician and for use as the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot) Box 68760. Due to (or es e consequence of) 88 The lew requires that the death 23b. Did tobacco usa contributa to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown been signed by Aq. Division of Vital Records, 24b. Wera eutopsy tindings eveilable prior to completion of cause ot deeth? 24a. Was en eutopsy performed? Completed Aftar this certificate has paga 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 2 No Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation or Attending s efter dean. 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours To the Funerel I 1 Cartifying Physician: To the best of my 2 Madical Examinar: On the basis of exe 29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. edicai pletaly 1 plnation end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified APRIL 03, 1998 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registra 31. Dete filed (Month, Day, Year)

GOLLE

MARIO



APR 08 898 With Marchald

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

if Under 1 Year

Days

EDWARD

WILSON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday)

51

Yrs

10c. City, Town or Location

Reg. No.

1946

4c. County of Death

PRINCE GEORGES

United States

Specify:

14. Race - American indian, Black, White, atc.

168

Birthplace (Stata or Foreign Country)

Washington, DC

Black

Landover, Maryland

20011

Approximata Interval Batween Onsat and Death

24b. Wera autopsy findings aveilable prior to complation of causa of death?

1XX as 2 No

Utas-on colleges

111 Penn Street, Baltimore, Maryland 21201

10d. Inside City Limits

XXXVes 2 No

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) James Edward Wilson, Jr.

10b. County

1**™** M 2□ F

APRIL 4b. City, Town, or Location of Death

HYATTSVILLE

if Under 24 Hrs.

2. Data of Daath

8. Data of Birth (Month, Day, Yaar) May 21, 19

3. Time of Deeth Yaar 04.1998 12:38A.M.

Funeral Director

with the Marylend r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at deeth Hygiena.

filed within 72 hours aftar 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oths eny injury or other traumatic event pages.

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s the burial-transit that the death certificate be executed 88 for use as signed by the a page 2 s certificate or Attending Physician: this funeral After 6

Division of Vital Records, P.O. Box 68760,

4e Facility Nema (If not institution, give street and number) KENILWORTH & EASTERN AVE 5. Social Sacurity Number 579-58-3131 Usual Rasidanca of Decedant Director Funeral þ Completed Be Examiner

Physician/Medical þ Completed Be 2

after 24 hours

Hospital To the Hosp within 24 hos To the Fune completaly fi State Registrar

Maryland Prince George Landover 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2324 Bright Seat Road 20785 Was Decedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S Armad Forcas? 11. Marital Status 1 Naver Married 2 Married 1 ☐ Yes 2X No If Yas, Giva 1 Yas 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry US Postal Service Collaga (1-4or 5+) 3 years Elamantary/Secondary (0-12) Postal Clerk 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) James Edward Wilson, Sr. Delores Lorraine Bourke 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 18 Destrial Lane Durham, North Carolina 27703

f Disposition (Nama of ry, cramatory or othar placa)

The property Memorial Cametary (1879)

Landover Market (1879) Miguel Wilson (Son) 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20e. Mathod of Disposition Buriel 2 ☐ Crametion 3 ☐ Ramoval from State Harmony Memorial Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Saprice License 22. Nama and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Avenue, NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heart fellura. List only one cause on each line. tmmediata Causa (Final 0/3 diseasa or condition resulting in death) ihu Dua to (dr as a consequence of): Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as e consequance of): Dua to (or as a consequance of) 23b. Did tobacco use contribute to the cause of death? Part tt. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy 1XXYas 2□No 25. Was case raferred to medical axaminer? 26. Placa of Daeth (Check only ona) Other: 4 Nursing Homa 5 Residence SCOther (Specify) ROADWAY Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Data of tnjury (Month, Day Yaar) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. injury at Work? Certification: 1 Natural 5 Pending 1 Yas 2 No 0035 M Investigation 4.4.98 2X Accidant Location (Streat and Number or Rural Routa Number City of Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. 4 Homicide Thret Konilworth & Eastern Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end placa, and dua to the cause(s) end manner as stated.

20 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, data and placa, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. Licensa numbar 29d. Date signed (Month, Day, Year) O.C.M.E. APRIL 4,1998

Ann Dixon M.D. 31. Data filad (Month, Day, Yaar) APR 09 1996

32. Registrar's Signatura

30. Name and ediress of person who completed cause of deeth (Itam 23a) (Type, Print)



Heaville 1

Division of Vital

Hospital or Attending Physician: efter death. 24 hours e completely To the within 2

> State Registrar

edicai

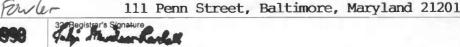
29a. Certifier

(Check only one)

Javia

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year) **APR 17**



30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner es stated.

Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

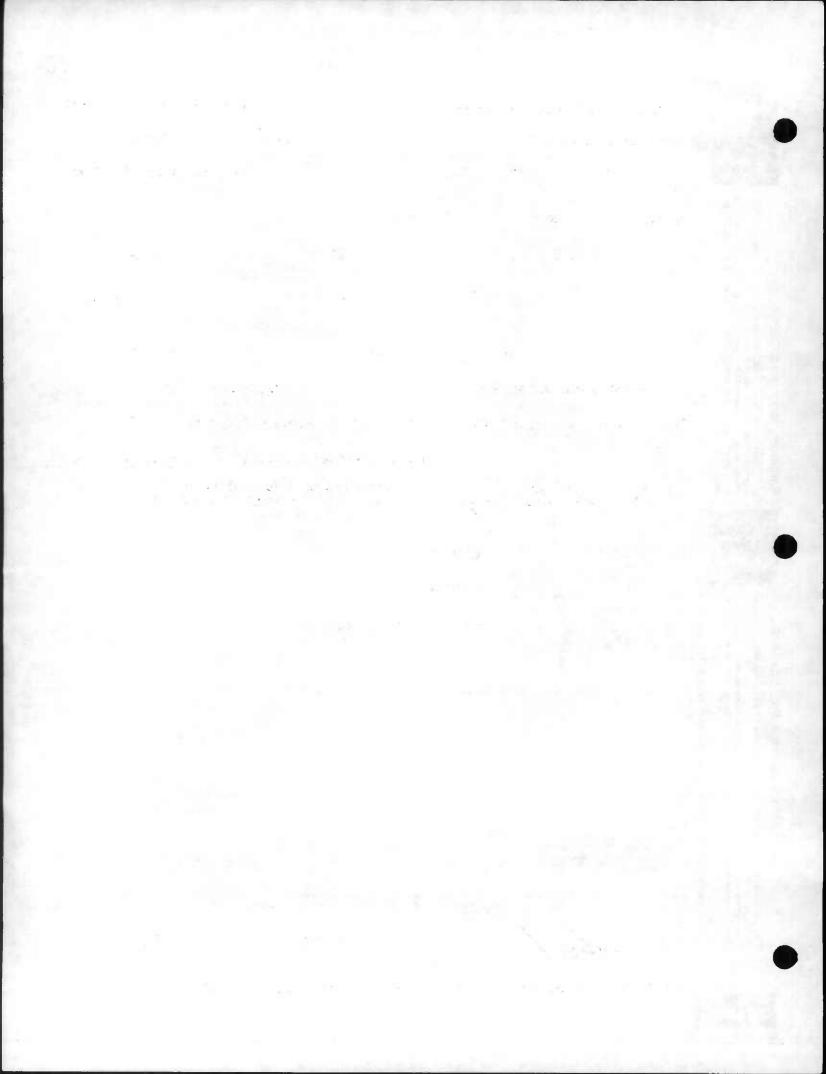
29d. Dete signed (Month, Dey, Year)

April 14, 1998

AND TO SEE THE PARTY OF THE PARTY.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Date of Deeth

		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate of L	Death	Reg. No. 98	12770				
	Decedent's Name (First, Middle, Last)			2. Date o		3. Time of Death				
Physiciar /Medica	(Loria Hornandoz	Wasenda		April	L 6, 1998	0335				
Examine	An English Alama Midwal inchination who also	t end number)	41	o. City, Town, or Location of E	Deeth 4c. County	of Deeth				
30 THE	Laurelwood Nursing Home Elkton Cecil									
Funeral Director	5. Social Security Number 116-18-4771 Usuel Residence of Decedent	7. Age (In yrs. lest birt	Honths Deys Months Deys	Hours Min. 3. Date of (Month) July	f Birth 1, Dey, Year) 12, 1925	Birthplece (Stete or Foreign Country) New York				
and w	10a. Stete 10b. County	10c. City, Town	or Location			10d. Inside City Limits				
the Marylan 28s-f show	Maryland Harford	Abino	gdon			1 ☐ Yes 2X No				
free death with the Ma r ferms 23a or 28a-fa	10e. Street and Number		10f. Zip Code 2100	00	10g. Citizen of W					
seth w	370-D Apt. 3	Vas Decedent Ever in U.S.			U.S.	A. American Indien,				
J. S.	3 XWidowed 4 □ Divorced	rmed Forces? ☐ Yes 2 TNo Yes, Give ear or Dates:	If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spenic Origin? (Specify Yes on n, Mexican, Puerto Rican, etc. Specify:	Specify:	k, White, etc.				
5-0 72 ho	15. Decedent's Education (Specify only highest grade con	n 16e.	Decedent's Usual Occupa (Give kind of work done d	tion uring most of working	16b. Kind of Bu	siness/industry				
ire, Maryland 21215-0 s 1 and 2 should be filed within 72 hd if Health end Mental Hygiene. Item 27 Is marked other than "natur other traumatic avent, tra Manical		Ollege (1-4or 5+)	(Give kind of work done d life. DO NOT use retired)		TNI hom					
ore, Maryland 212: ss 1 and 2 should be filed within of Health end Mental Hygiene. itiam 27 is marked other train other traumatic avent, trail.		U HC	omemaker	18. Mother's Name (First, Mi	IN home					
and the fill be fill be fill be fill be fill be						0)				
hould I	Waldo Lewis Herr		Mailing Address (Street a	Kathryn Mar: and Number or Rural Route N	-	State Zin Code)				
Maryland d 2 should be file th end Mental Hy the and Mental Hy traumatic avent traumatic avent	Service and the service of the servi			Ave., Oceanpo		7757				
Te, 1 an Heal mm2	20a. Method of Disposition	20b. Plece of	Disposition (Neme of	Date		City or Town, State				
timo tranto tant: If	1 № Buriel 2 □ Cremation 3 ☑Remo 4 □ Donation 5 □ Other (Specify)	val from Stete	y, crematory or other please	l Cemetery 4/8/98		on, Virginia				
Bal Permi Import	21. Signeture of Funeral Service Ligensee	Cours	Aberdeen.	argo Funeral I	001-3399					
	23e. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the deeth. Do nuse on each line.	not enter the mode of dying	, such es cardiec or respireto	ory errest,	Approximete Intervel Between				
Physician						Onset and Deeth				
/Medical Examiner	Immediate Ceuse (Final disease or condition	CAD								
	resulting in death)	Due to (or as a c	consequence of):							
executed in and ital-transit	Sequentially list conditions,									
o e exe	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of):									
68760, tificate be executed g physician and es the burial-transit										
ds, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and doe deteched for use as the burist-transit	d	tion to death but not requising in	the underhine eques sho	on in Part I 29h	Did tobacco use cor	ntribute to the cause of death				
P.O.	Pert II. Other eignificant conditions contribu	ang to death but not resulting in	Title underlying couse give	THE POLICE.		3 Probably 4 Unknow				
S, F se that gened be de										
need lihodi				248.	Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
Vital Rec					1□ Yes 2□No	1 ☐ Yes 2 ☐ No				
Vital sician: Tr certificate irector, pe				26. Place of Death (Check of	only one)					
Of Vita Physician: this certific ral director,	examiner? 1 Yes 2 No	tal:	tpatient 3 DOA Othe	ar: 4 ☐ Nursing Home 5 ☐	Residence 6 □Oth	er (Specify)				
Attending Physic actor: After this by the funeral di			Fime of njury 28c. Injury Work	at 28d. Desc ?? res 2 \(\text{No} \)	ribe how injury occurr	ed				
Division c tal or Attanding P rs after death. led in by the funers	3 Suicide 6 Could not be determined 2	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street								
Division of Vita To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medicat Examiner:	n: To the best of my knowledge On the basis of examination en- end manner steted.	, death occurred et the tim d/or investigation, in my op	e, date and plece, end due to pinion, deeth occurred at the	the cause(s) and ma time, date and place, t	nner as stated. and due to the ceuse(s)				
To the within To the comp	29b. Signature and title of certifier		29c. License D323		29d. Date signed 4/6/9	d (Month, Dey, Year)				
\	30. Name and address of person who complete	eted ceuse of death (Item 23a)	(Type, Print)							
	Thomas E. Finucan. M.	AS DESIGNATION OF THE PARTY OF		Fact MD 210	01					
State	31. Date filed (Month, Dey, Yeer)	32 Aggistrar's Signature	Ave. North	East, MD 219	VI.					
Registra	ADD U TUUU	July asimulation	Dro all							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Amonth. 6:58 AM **Physician** 3 Wheeler aure -YND /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hookins Hospital Johns Baltimore If Under 1 Yeer If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 20 F Yrs Director 217-08-2320 28 Dec. 27, 1969 Texas Usual Rasidence of Decedent r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Maryland Directo Harford Aberdeen 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23s or itemmetic event, the Medical Examples maint be to Funeral 430 Paradise Road 21001 USA 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 🖾 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) permit. Peges 1 and 2 should be filed within 72.1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natu any injury or other traumatic event, the Mulical Once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Wheeler, Joseph Anderson Sr. Judith Lee Lowman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Judith L. Wheeler - Mother 208 Farm Road, Aberdeen, Maryland 21001 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-8-98 Hilltop Service Corp. 4 □ Donation 5 □ Other (Specify) Towson, Maryland 22. Name end Addrass of Fecility Howard K. McComas III Funeral Home, P.A. 4llow a 1317 Cokesbury Rd., Abingdon, MD 23a. Part1. Enur the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** Immediate Ceuse (Final disaasa or condition resulting In death) /Medicai Sepsis Examiner Due to (or as a consequenca of): Physician/Medical Examiner Immuno Suppression Due to (or as a consequence of): eight years Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events Heart Transplant Due to (or es e consequence of): nine years resulting in death) Last 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown Atherosclerosis þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas t ☐ Yes 2 No 2□ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide

The law requires that the death certificate be executed attending physician and for use es the bunal-trensit Box 68760. use es t Division of Vital Records, P.O. the been signed by has certificate Physician: Director: After this d in by the funeral di or Attending death. efter within 24 hours e To the Funeral C completely filled To the Hospital

the Maryland

with t

72 hours after death

Maryland 21215-0020

6 Could not be datermined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier

(Check only one) 29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Dey, Year)

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RES-000

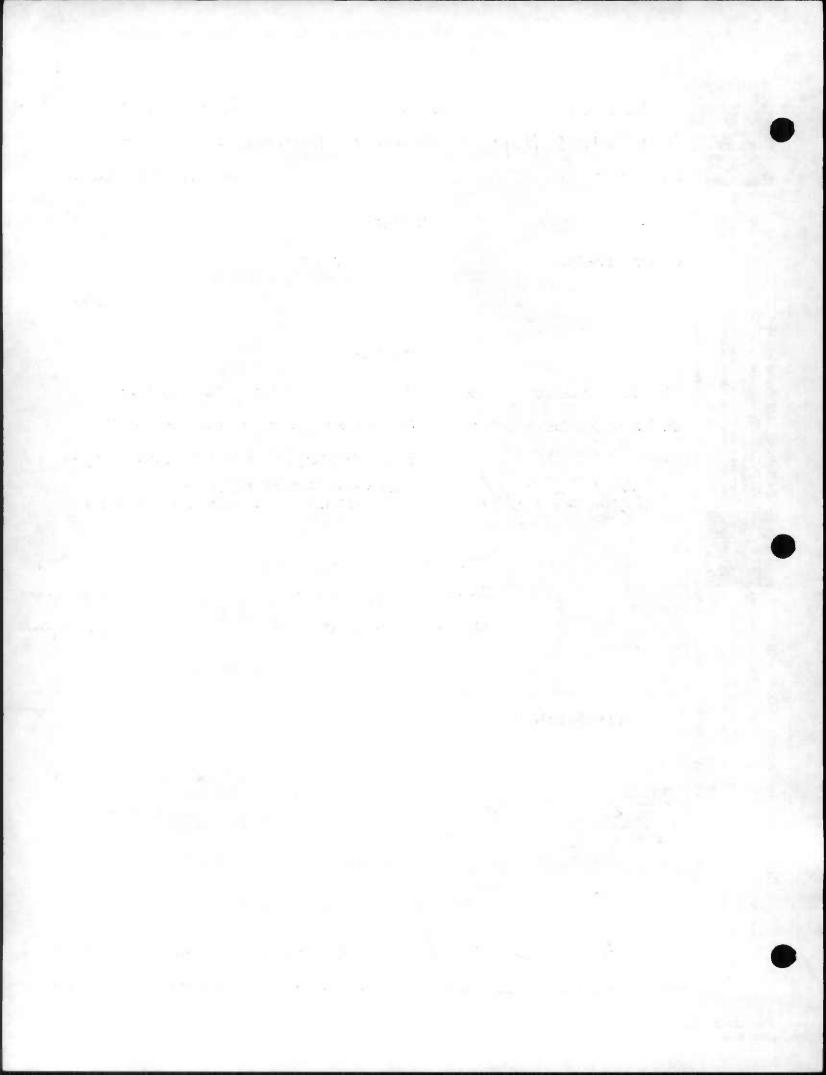
30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

600 North Wolfe Street Johns Hopkins Hospital, Batti mare MD 21287 Ja. Dete filed (Month, Day, Year) 32. Registrar's Signeture

Registrar

2

edical



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth **Physician** Month MARGARET ANN WAGNER 5:50 P.M. APRIL 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HEALTHCARE BALTIMORE If Undar 24 Hrs. 8. D 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 8. Deta of Birth (Month, Day, Year) **Funeral** 1 M 283 F Months Days Hours Yrs. Director 213-26-7384 68 Nov. 24, 1929 Maryland Usual Residence of Decedent death with the Maryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Llmits ns 23a or 28a-f sh must be notified Mas 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 201 D Yorkshire Way 21014 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Biack, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 5 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: by Specify: 3 ☐ Widowed 4 M Divorced "nature!", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry than Elementery/Secondary (0-12) Coliega (1-4or 5+) 12 Property Manager Housing 7 is marked other traumatic event, i Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Theodore E. Gross Edna Mae Fowler 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health an important: If item 27 is any injury or other trauonce. Thomas M. Wagner - Son 101 Colony Place, Bel Air, Maryland 20b. Pleca of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Mt. Zion U.M. Cemetery 4-7-98 Bel Air, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 23a. Pert f. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset and Deeth **Physician** /Medical Immediate Cause (Final & BRONCHOPNEUMONIA diseese or condition resulting in death) WEEKS Examiner Due to (or es e consequenca of) EMPHYSEMA. Y GARS requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting In deeth) Last pue Due to (or es e consequence of): FAILURE YEARS CONGESTIVE HEART Physician/Medical the Due to (or es a consequenca of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been signed page 2 should be de ò 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 2 19 No 1 Yes 2 No After this certificate 1 Yes director, 25. Wes case referred to medical Be 26. Place of Daath (Check only one) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To of the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? Attending 5 Pending investigation 1 Naturei death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicida 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 5 To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signatura and title of contil 29c. Licansa number 29d. Date signad (Month, Day, Year) 11704 APRIL 4, 1998 mo 8 30. Name and address of purson who completed cause of deeth (Item 23a) (Type, Print)

M.P. 900 CATON AVENUE, BAUTIMONE, MD, 21229.
32 Registral signature landal

DHMH 16 Rev 6/95

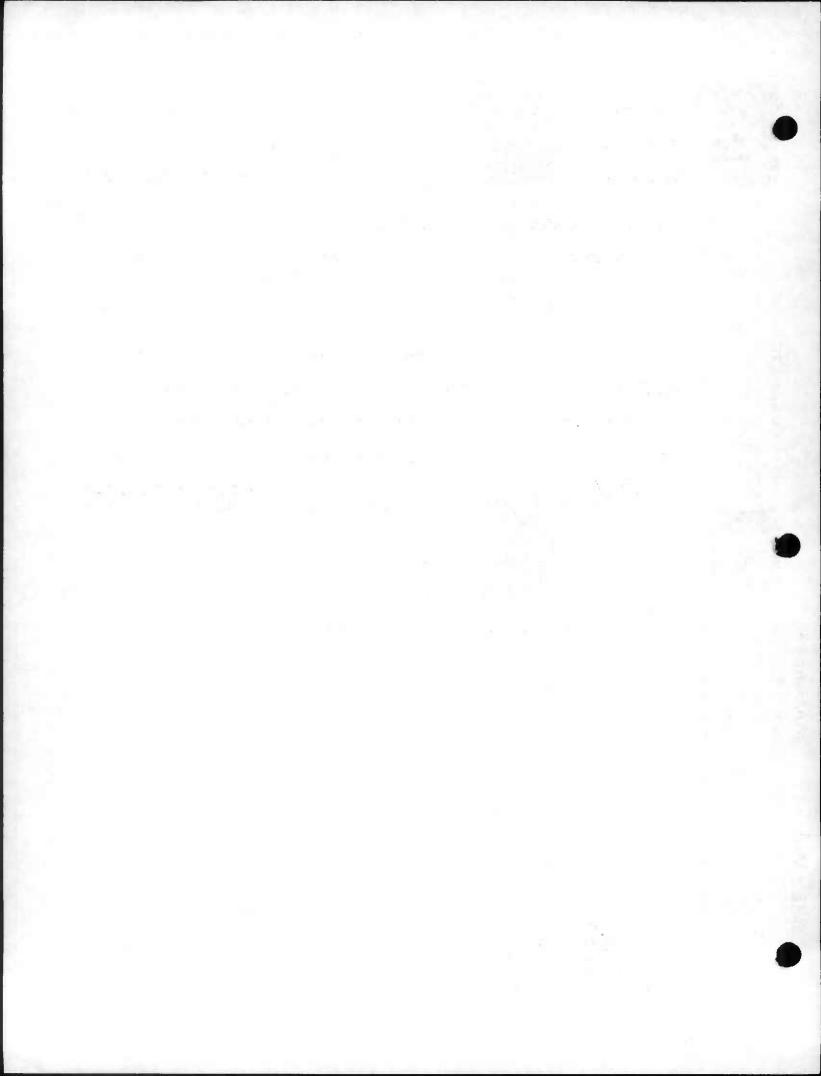
State Registrar

GHANI

MAZEN 31. Dete filed (Month, Day, Year) M.P.

MARGARET

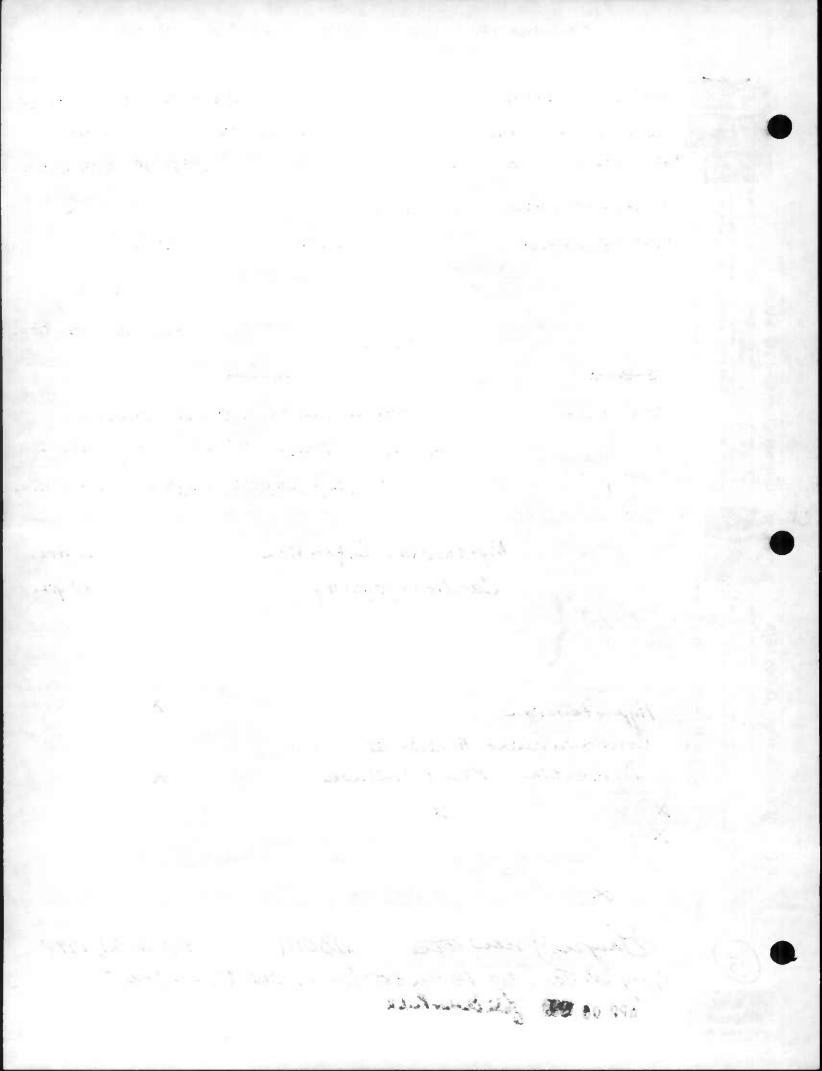
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State of Maryland / Department of Health and Mental Hygiene

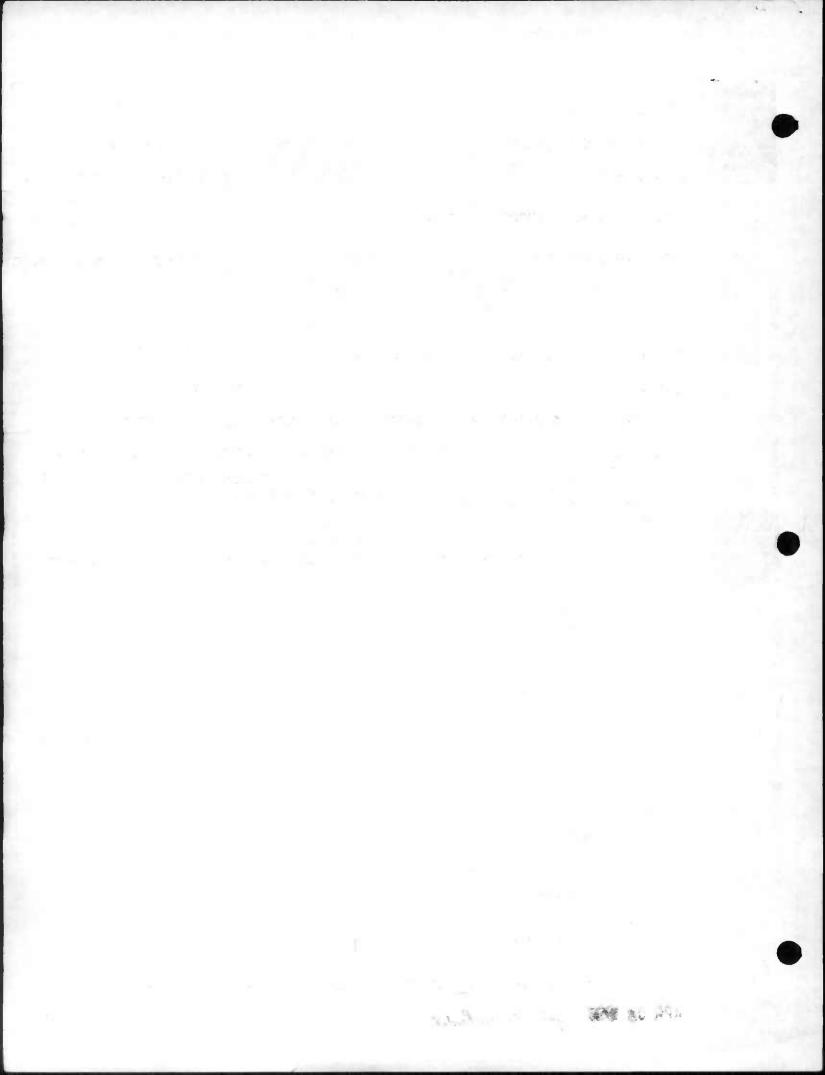
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/Medica Examine	4n English, Manna //f ne)			4b. City, Town, or Olney,	ocation of Death	4c. County	of Death	-
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ifter death with the Mark ferms 23a or 28a-fe	10e. Street and Number 2610 Be	lpre Ro	ad			10f. Zip Code 209	906		10g. Citizen of W U.S.A	het Coun	try?
JIS 8	3 ☐ Widowed 4 [12. Was Deceden Armed Forces 1 Yas 2 Rit Yes, Giva Year or Dates	? No		as Decedent of I Yas, specify Cub	Hispanic Origin? (Span, Maxican, Puerl	pecify Yes or No o Rican, atc.)		- America c, White, e Bla	etc.
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Baltim permit. Pa Departmen important any injury anse.	21. Signature of Fune	ral Service Licens	Dubin	9	22. I	Name and Address Cobinso Vashing	ess of Facility In Funer Con ,	al H27	801313	6th	st. N.W.
hysician // Medical personned as the buris-transit	Immediate Cause (Fir disease or condition resulting in death) Sequentially list condition in any, leading to immediate. Enter Underly	nal	a. My control of the	Due to (or	as a conseque	partte	vetion				5 Hrs. 20 Ws.
S, P.O. BOX (set that the death certification of the strending be detached for use as the box of the set of t	Part II. Other significa	nt conditions co		but not resu		lerlying cause gi	iven in Part I.	10	Yes 2 1 No	3 □ Prot	o the cause of death?
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of Vital Re	25. Was case reterred examiner?	I to medical	Hoepital:			0	ther:	eth (Check only o	4 4 5		
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To the Hospital within 24 hours e completely filled		Certifying Phy Medical Exam	rsician: To the bes iner: On the basis and manner s	ot examinati	vledge, death o ioh and/or Inve	occurred at the t estigation, in my	ime, dete end place opinion, deeth occi	a, and due to the arred et the time,	cause(s) end ma date and plece,	nner as st end due to	teted. o the cause(s)
To the within To the comp	29b. Signature and tel	yw.	Jones	ai	8		SOIII		29d. Date signed March		
9	30. Neme end address Pary 31. Date tiled (Month,	W. Jon		Po B trar's Signat		5 Lau	rel Ma	2072	5.038	5	

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Š	/Medi Exami		4e. Facility Name				mber)				4b. City, Town,			4c. County		
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	Funeral		5. Sociel Security		6. Se	X	7. Aga (In yi	rs. lest birti		Under 1 Yea	r If Under 24 h	Ins. 8. Det	e of Birth onth, Dey,	PRINC		plece (Stete or Foreig intry)
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	s 1 and 2 should be filed within 72 hours efter death with the Meryland (Heelth end Mertel Hyglene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Evanther must be notified at	by Funeral Director	11. Maritel Status 1 ☐ Never Ma 3 ☐ Widowed	rried XX Me		12. Was Deci Armed Fo 1 Yes If Yes, Giv Yeer or D	rces? 27 No va	U,S.		Decedent of es, specify Cu	Hispanic Origin? ban, Mexican, Pu Specify:	(Specify Ye Jerto Rican, o	s or No- etc.)	14. Rac	ca - Ameri ck, Whita,	can Indien,
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	to the Hospital of within 24 hours of to the Funeral Dicompletely filled in	edical C	29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Madica	ng Phys I Examir	sician: To the ner: On the be and menr	isis of exemin	nowledge, netion end/	deeth occ	curred et the t getion, in my	ime, date end ple opinion, deeth o	ace, end due	to the ce	use(s) end me te end plece,	enner as s	steted. the ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene \(\text{\$\text{\$\gamma\$}} \) Certificate of Death 2. Dete of Deeth 3. Tima of Death Month MARCH 31 1998 1015 4b. City, Town, or Location of Death 4c. County of Death

/Medical **Examiner**

Funeral Director with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mentel Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Modical Examines must be nother as

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

deeth certificate be axecuted

Box 68760

P.O.

Division of Vital Records,

ettending physician and for use es the burief-transit funerei of or Attending P s after deeth.

I Director: After t din by the funers

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To the Hospital within 24 hours of To the Funeral I completely filled

filled in by

1. Decedent's Nama (First, Middla, Last) **Physician** HENRY B. ADAMS 4a. Fecility Nema (If not Institution, giva street and number) ANNAPOLIS
If Under 1 Year If Under 24 Hrs. ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL 5. Sociat Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1 € M 2 □ F Months Deys Hours Min Yrs. 115-22-7361 JULY 6 1926 TEXAS 71 Usuel Rasidance of Decadant 10e Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Coda 10g. Citizan of What Country? Funeral 509 CHESAPEAKE AVENUE 21403 US 12. Wes Dacedant Evar in U,S. Armed Forces? 1 K) Yas 2 □ No If Yes, Giva Yaar or Datas:1942-72 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 11. Maritai Status 1 Navar Married 200 Married 1 ☐ Yas X2 XXXIvo Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltega (1-4or 5+) 12th COOK US NAVAL ACADEMY 17. Fathar's Name (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be SAMUEL ADAMS ELIZABETH THOMAS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 509 CHESAPEAKE AVENUE ANNAPOLIS, MD. 21403 ARLENE V. ADAMS (WIFE) 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata P⊟Burlal 2 □ Cramation 3 □ Ramovat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MARYLAND VETERAN CEMETERY 4/7/98 CROWNSVILLE, MD. 21. Signatura of Funaral Sarvica Licansas 22. Nama and Address of Fecil WM. REESE & SONS MORTUARY, P.A. esaa 821 WEST ST. ANNAPOLIS, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarvet Between Onset and Death Immediata Cause (Final disaasa or condition resulting in deeth) WKS Dua to (or as a consequence of): Examiner Rev Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaese or injury that initieted avants rasulting in daath) Last Dua to (or as a consequence of): 2450 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in tha undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown b 24a. Was an autopsy 24b. Were eutopsy findings Completed available prior to completion of causa of death? performed? 2 No 1 Yas 1 Yas 2 No Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Hospitel: 1 Inpatient Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 25 No 10 2 ER/Outpatient 3□ DOA 27. Mennar of Death 28c. Injury at Work? Certification: 28d. Dascribe how Injury occurred 1 Neturel 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 Homicide 15% Certifying Physician: To tha best of my knowladga, daath occurred at tha time, date and piece, and dua to the ceuse(s) end menner es steted.
2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, daeth occurred et tha time, data end pieca, and dua to tha causa(s) and mannar statad. 29a. Certifiar Medical (Check only 29b. Signatura and titia of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

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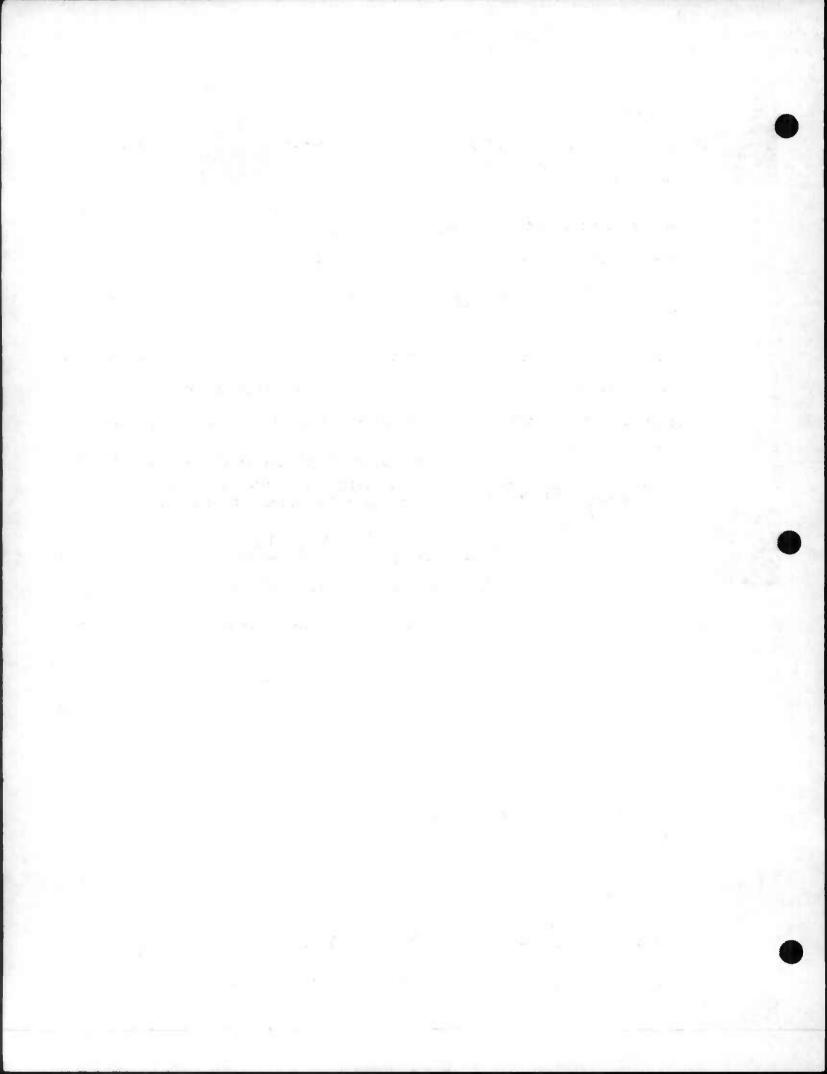
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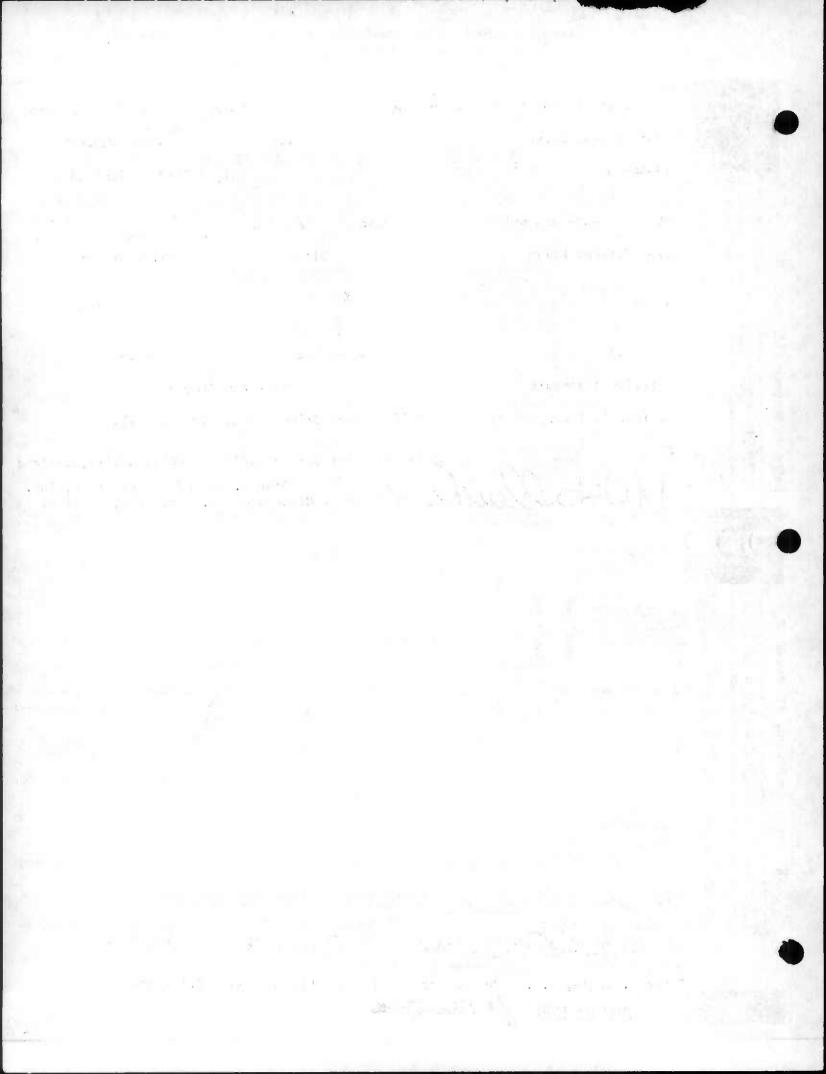
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30. Name and addrass of person who complated cause of death (ttam 23a) (Type, Print)

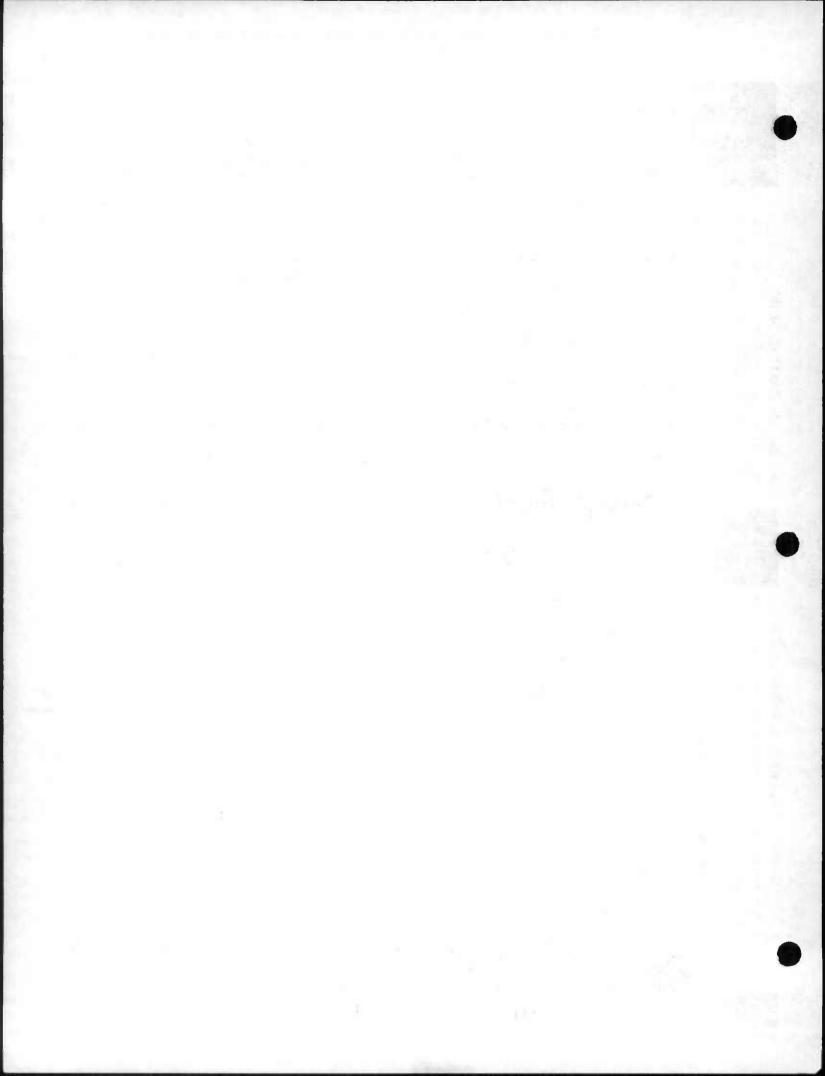


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						Ce	rtificate of	Death		Reg. No.		
П	Physic	ian	Decedent's Neme (First, Middle						2. Dete of De Month	eeth Dev	Yeer	3. Time of Deeth
	/Medi		Lucille		kinson-S	tone	2		March	30	1998	12 Noon
Š	Exami	ner	4e. Fecility Neme (If not institution		per)				or Location of Deet	th 4c. Coun	ty of Deeth	
L			2708 Plateau		A		H Hader 4 Vees	Riva			ne Aru	
L	Funeral Director	I	5. Sociel Security Number 213-54-8505 Usuel Residence of Decedent	6. Sex 7 1 □ M 2 🔏 F	Age (In yrs. lest bi	Yrs.	If Under 1 Year Months Deys		in. (Month, De	nth ey, <i>Year)</i> 4 1917	9. Births Cour Micl	plece (Stete or Foreign http) higan
	/land		10e. Stete 10b. County		10c. City, Tov	vn or Lo	ocation				1	10d. Inside City Limits
	Man,	to	MD Anne	Arundel			Riva					1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
	th wil	ai	2708 Plateau	Drive				21140		Unite	ed Sta	ates
21215-0020	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Medical Examiner trust be notified as	by Funeral Director	11. Maritei Stetus 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Wes Deceded Armed Force ed 1 Tyes 2 if Yes, Give Yeer or Dete	es? ՃNo		Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No erto Rican, etc.)	Speci		
2-0	72 ho	ted	15. Decedent	's Education	166	. Decad	dent's Usuel Occup	petion	200	16b. Kind of I		
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and	Should be filed within and Mental Hygiene. Smarked other than summitic event, the Mental County that Mental County the Mental County that Mental County the	Be	17. Fether's Neme (First, Middle, L	r					lame (First, Middle		me)	
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Maryland	d2sh ih and 7 is n treun		19e. Informent's Neme/Relationsh Dwight Atkin		190	o. Meilir 708	ng Address (Street	end Number or	Rurel Route Numb Riva, Ma	er, City or Town	n, Stete, Zip	Code)
	The land		20e. Method of Disposition	(5011)	7		sition (Name of	DIIVE	Dete Dete			
Baltimore,	S C T		Mariei 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp		cemete	ry, cren	netory or other ple	,		20c. Location		
	- 545		21. Signature of Funeral Service L		Lakemo) II L	Neme end Addre	Gardens	4/3/98	Davids	onvil	lle,Marylan
B	Depare Important in any		Mutte	Ma	ul						eral	Home, Inc. MD 21401
			23a. Pel . Enter the disease, or c shock, or heert feilure. List of	complications that cau only one cause on eec	sed the deeth. Do h line.	not ente	er the mode of dyl	ng, such es cardi	iec or respiretory e	rrest,		Approximete Intervel Between
	Physician /Medical Examiner		Immediate Cause (Finei disease or condition resulting in death)	Θ	LUNG	- (ANZE	R				Onset and Death
	n #	ner			Due to (or es e	conseq	uenca of):					2222000000
68760,	certificate be executed ding physician and use es the buriel-transit	Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest	b. ————————————————————————————————————	Due to (or es e							
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	0 0 2	Physician/	Pert li. Other significant condition	s contributing to deat	n but not resulting i	n the ur	nderlying cause gh	ven in Pert I.	23b. Did	tobacco use co	ontribute to	the cause of death?
P.0	es that the de igned by the be detached	by Ph	CHROMIC	OBSTR	UCTIVE	F	runor	MRY	DISKAR	2□ No	3 ☐ Prot	bably 4 Unknown
of Vitai Records,	aw requir is been s 2 should	Completed b								en eutopsy ermed?	COL	ere eutopsy findings ailable prior to mpletion of cause deeth?
<u> </u>	0 5 6	NO.							10	Yes 2 No	10	Yes 20 No
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>	5 00 0	2	1 ☐ Yes 25 No	Hospitei: 1 🗆 Inpe	atient 2 ER/Ou	itpatieni	t 3 DOA Oth	er: 4 Nursing	Home 5 Resi	dence 6 Ot	her (Specify	y)
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Sio	Attending or death. actor: After by the fune	cati	2 Accident Investige 3 Suicide 6 Could no	otion ot be				Yes 2 □ No				
Division	or Attending after death. Director: After in by the fune	Certification:	4 ☐ Homicide determin	ed 289. Pieca of	Injury - At home, fa etc. <i>(Specify)</i>	rm, stre	eet, fectory, office		28f. Location (: City or To	Street end Num vn, Stete)	ber or Rura	I Route Number,
	To the Nospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying	Physician: To the be	st of my knowledge	, deeth	occurred et the tir	ne, dete end pied	ca, end due to the	cause(s) end m	enner as st	ated.
	in 24 in 24 he Ft	edica	(Check only one) Medicai E	kaminer: On the besis	or examinetion en	d/or inv	estigetion, in my o	pinion, deeth occ	curred et the time,	dete end piace,	end due to	the ceuse(s)
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			reten	BY WIR	MI	1		1636	4	3/3	110	5
			30. Neme end eddress of person w	ho completed cause o	f deeth (Item 23e)	Type, F	Print)					
			Peter R. Graze,		Bestgat			oolis, M	D 21401	(410-57	3-530	0)
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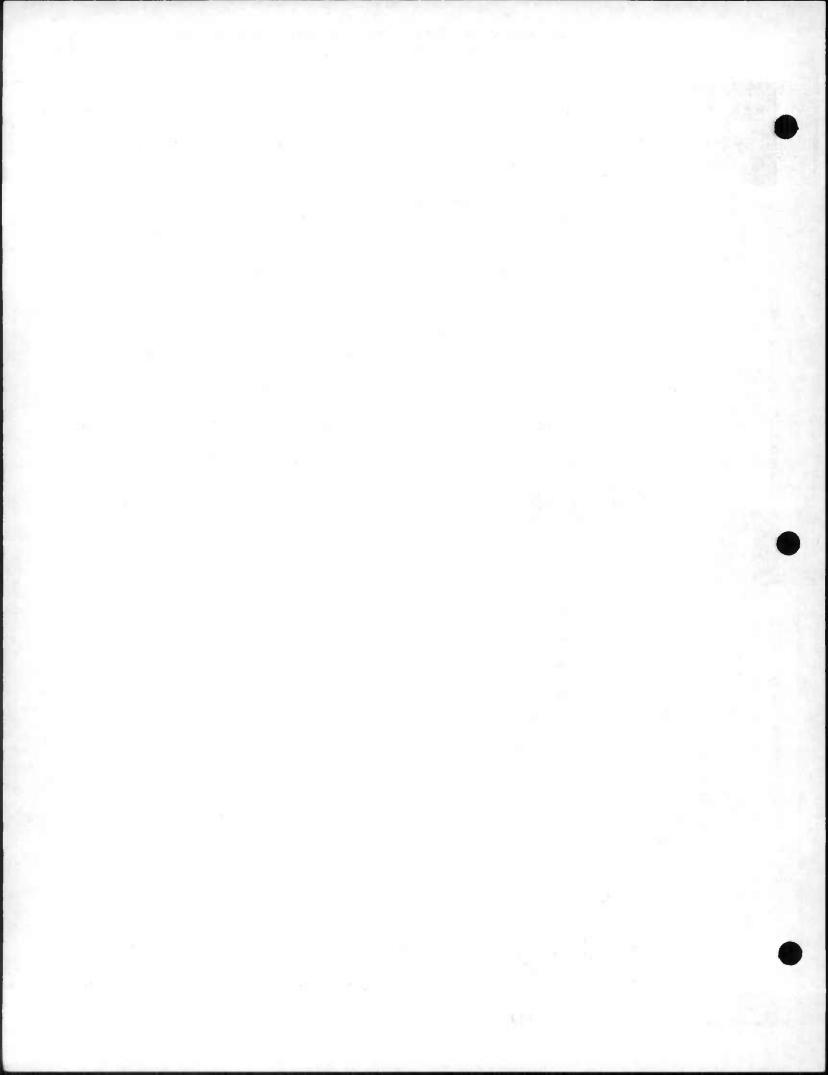


		_0	1. Decedent's Name (First, Middle, La	ist)		Jen	tificate of	Dealli	2. Dete of De	Reg. No.		3. Time of Death
	Physic		Anthony Leo	ANNARI	ELLT				Month	Dey	Year	4:00 PM
	/Medi Exami		4e. Fecility Neme (If not Institution, give					4b. City, Town, or			of Death	4:00 PM
	Examili	101	1286 Green Glade	Road				Swan	ton		rrett	
	Funeral		Sociel Security Number 6. 3	Sex 7. Ag	e (In yrs. lest b	irthday)	if Under 1 Yea Months Devs	r If Under 24 Hrs	s. 8. Dete of Bi	rth		iece (Stete or Foreiar
Н	Director	П	210-07-0909	1⊠M 2□F .	79	Yrs.	WORKI'S Dey	S TIOUIS WIII	Sept.	30, 1918	Mary	land
	and **		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
	Maryl	ō	MD Garr	ett	,		nton					1 ☐ Yes 2 ☑ No
	T 28e	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	Whet Coun	
	h with		1286 Green Glade	Road				21561		US	A	
	deat	Funeral	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. W	as Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	0- 14. Red	e - Americ	
Maryland 21215-0020	d within 72 hours after death with the Maryland piena. r than "natural", or itema 23a or 28a-f ehow tra Madical Exarrance mast be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 f If Yes, Give Yeer or Detes:			☐ Yes 2 No		no moan, etc./	Specify		White
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gro	ducation	16	a. Decede	ent's Usuel Occu	upation e during most of wo	ndeina	16b. Kind of B	usiness/ind	dustry
121	within ena.	mple	Elementery/Secondery (0-12)	College (1-4or 5	i+)	life. D	O NOT use retir	red)	// Kuig			
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and	ad be of or or ove	Be C	Michael	Annar	۵11 1			Mary	me (First, Middle Agnes	-	rezza	
Ž	shoul nd Me mark	2	19a. Informent's Name/Relationship			b. Mailine	Address (Stree	et end Number or F				Code)
S	nd 2 :		Gertrude M. Anna				,	lade Road				21561
re,	f Herm		20a. Method of Disposition		20b. Piace	of Dispos	ition (Neme of etory or other pl		Date	20c. Location		
altimore,	Page nent c int: if iry or		1 ☑ Buriei 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia				Cemete	· ·	4/6/98	Deer I	Park,	Maryland
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plicetions that caused one cause on each lin	the death. Do	not ente	r the mode of dy	ring, such es cardie	oc or respiretory	errest,	and	Approximete intervel Between
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	/Medical Examiner		immediate Cause (Final disease or condition resulting in death)	. Arte.	riole	scle	protic	Curono	mar	114019	eal	year s
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	d d ansit	Examiner	Securetially list conditions	b	Due to (or es a	consequ	ience of).				- 1	
ó	an an iriai-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due 10 (01 e3 t	consequ	ionoe oi).				1	
68760,	ficate be axecuted physician and is the bunal-transit	edical	Ceuse (Disease or injury that initiated events resulting in deeth) Lest	C	Due to (or es e	consequ	enca of):					
				d							1	
Box	The law requires that the death certifules has been signed by the attending page 2 should be datached for use a	Physician/M		0.								
0.0	he de	ysic	Pert II. Other significant conditions of	ontributing to death be	ut not resulting	in the un	derlying cause g	given in Part I.				the cause of death'
	that i								. 1	Yes 2□ No	3 ☐ Prol	bably 4 M Unknow
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Sio	Attending Physician: or death. ector: After this certific by the funeral director,	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Α				Yes 2 No				
Division of Vital Records,	Hospital or Attended by hours after deat Funeral Director: staly filled in by the	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, to c. (Specify)	arm, stre	et, factory, office			(Street end Numb wn, State)	oer or Rure	I Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completaly filled in by the funeral director, page	edicai (yalcian: To the best on niner: On the basis of end manner ste	examination e							
	within 2 To the comple	Me	29b. Signature end title of cartifier				29c. Licer	nse number		29d. Date signe	d (Month,	Dey, Yeer)
)	V- 21- 0		1 Spent	Data	X	-		H26154		April	. 3,	1998
		, , 0	30. Name and address of person who	completed cause of di	eth (item 23a	(Type, P	rint)					
	10-	4/1	Dr. P. Daniel Mi	ller, DO	69 Wo.	lf Ac	res Dri	ve, Oakl	and, Mar	yland :	21550	
	Sta		31. Date filed (Month, Day, Year)	A COLOR	r's Signature		100					
	Registr	- 1	APR - 8	DOO P	SHALL GOVERNOR	WALL STATE	THE PERSON I					
υH	MH 16 Rev 6/9	9										



State of Maryland / Department of Health and Mental Hygiene

			•	Certif	icate of	Death		Reg. No.		
		1. Decedent's Name (First, Middle, L.	ast)		13		2. Dete of D	eath		3. Time of Death
Physic		Daisy Imoge	ne ALEXAND	ER			Month April	6. 1998	Yeer	9:00 AM
/Med Exam		4a. Fecility Neme (If not institution, gi		LIK		4b. City, Town, or			of Death	J. 00 M.
LAGIII	illei	401 L Street				Mt. Lake	Dark	Garre		
Francis			Sex 7. Age (In vrs	. last birthday) If	Under 1 Year					e (State or Foreign
Funera Directo			1□M 2XF 72		onths Deys		. (Month, D	ay, Year)	Country	e (Stete or Foreign
		Usuel Residence of Decedent	14				OCL.	20, 1925	maryı	and
dand dand		10e. Stete 10b. County	10c. C	ity, Town or Location	on				10d	. Inside City Limits
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r 28a-f ehow	Director	10e. Street and Number			Of. Zip Code			10g. Citizan of	What Country	2
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s 23a	Funeral		10 Mac Decedest Free to 1	16 40 1/10	December of		2			1-47
Per de	5	11. Marital Status	12. Wes Decedent Ever In I Armed Forces?	If Ye	s, specify Cul	Hispenic Orlgin? (S ban, Mexican, Pue	to Rican, etc.)	O- 14. Had	ce - Amaricen ck, White, etc	
20 saft	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☒ No If Yes, Give	10	Yes 2₩ No	Specify:		Specif	y: 1,71-	nite
Maryland 21215-0020 d 2 should be filed within 72 hours at the nd Mental hylgiena. 7 Is marked other than "natural", or traumatic event, the Medical Experi		**	Year or Dates:	1						
72 172 Inst	Completed	15. Decedent's E (Specify only highest gr	ducation e <i>de</i> com <i>pleted)</i>	16e. Decedent' (Give king	s Usual Occu of work done	pation during most of wo	orking	16b. Kind of B	usiness/Indus	try
2121 3 within jiena. r than "	E G	Etamantary/Secondary (0-12)	Collage (1-4or 5+)					_		
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tal H d ott	8	17. Fether's Name (First, Middle, Las						a, Maiden Sumen	10)	
Via Men Men Men Men	2	Robert Elwoo	d Paugh			Virgie	E1	len	Moore	
re, Maryland stand stand stands that the Mantal Hy ten 27 is marked other traumatic event.		19a. Informent's Name/Reletionship	Type, Print)	19b. Mailing A	ddress (Stree	t end Number or A	ural Route Numi	ber, City or Town,	Stata, Zip Co	ode)
t end the Health		Sharon M. Rinker	/Daughter	406 L	Street	t, Mt. La	ke Park	, Maryla	ind 21	.550
of He other		20a. Method of Disposition	20b.	Piace of Dispositio	n (Neme of	ace)	Data	20c. Location	City or Town	, State
Baltimore, Semit. Pages 1 er Depertment of Hea mportant: if item;		1 ☐ Burlel 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	Tuelliovel Ilolli Stefe	rrett Co			1/9/98	0akland	Mars	rland
Baltimore, permit. Pages 1 en Depertment of Heal Important: if item 2 any injury or other once.		21. Signature of Funerel Service Line				ess of Fecility	7/ // //	Cartano	i, mary	Tand
Bal Deperminent		D M A	1			Funeral H	lome			
		Broken H	Deward	32	S. Se	cond St.,	0aklan	d, MD 2	1550	
		23a. Part1. Enter the disease, or con shock, or heart failura. List only	pications thet caused the dea one causa on aach lina.	th. Do not enter th	e mode of dy	ing, such es cardia	c or respiretory	errest,	in	pproximate terval Between
Physician	_	A PERSON AND A STATE OF THE STA							O	nset and Death
/Medical		Immediata Cause (Final diseese or condition	COPD						1	Years
Examiner	L.	rasulting in death)	Due to (or es a consequan	ce of):					
D ==	nei									
58760, icete be executed physician end s the burial-transit	Examiner	Sequentially list conditions.	b. Due to (or as e consequen	ce of):					
O, exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							1	
68760, ficete be ex physician st the buria	cal	that initiated events	C. Due to (or es e consequenc	ce of):				1	
ox 68760, certificete be execut rding physician end use es the burial-tran	Medical	resulting in death) Lest	200 10 (or our or contouquone	JO 017.					
Box attendin for use	3	_	d							
death death of for u	Cla	Datil Others I will and a state of								
IS, P.O. BOX es that the death cer igned by the attendir be detached for use	Physician/	Part II. Other significent conditions	contributing to death but not re-	sulting in the under	tying cause gi	ven in Pert i.				e cause of death
that the	T	Osteoporosis,	/ears				1 🔀	Yes 2 No	3 Probab	oly 4 Unknow
sign d be	l by							-38V(1-, 1	Data Mara	autonou dia dia ma
cords requires been sign	Completed	Hip Fracture,	One Month				249. Wa	s an autopsy ormed?	avaite	autopsy findings ble prior to letion of cause
Rec e law has b	d.								of das	ith?
The Language	00						1 🗆	Yes 2∑No	1□Y	es 2 No
Vital I	Be (25. Wes case referred to medical				26. Plece of De	ath (Check only	ona)		
of Vital Records, Physician: The law requires the this certificate has been signeral director, paga 2 should be to	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpetient 3	B DOA OI	her: 4 Nursing I	Home 5 ☑ Ras	idance 6 Oth	ar (Specify)	
Phys er this		27. Mannar of Death	28a. Data of Injury (Month, Dey Yeer)	28b. Time of	28c. Inju		-	how injury occur		-
Afr. Afr	et e	1 Naturat 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 No				
Division or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not b		nome, farm, street,	fectory, office		28f. Location	(Street and Numb	per or Rural R	oute Number,
D afte	ert	4 ☐ Homicida determined	building, efc. (Speci	ify)	•		City or To	iwn, Stete)		
ours eral	C	29a. Certifier 1 1 Certifying Pt	ysician: To the bast of my kno	outodes death occ	urrad at the t	ima data and alaa	a and due to the	anuan(a) and m	annar an atatr	
Hos 24 h Fun stely	edical		niner: On the basis of examina	ation and/or Investi	gation, in my	opinion, death occ	urred at the time	, date end place,	and due to th	e ceuse(s)
DIVISION Of VITA To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signature and title of partified	and manner stated.	3555	200 Lines	se number	Т	20d Date slave	d (Month Do	v Vaarl
F ₹ 5 8				0	230. LICHN			29d. Date signe		, roar)
		1	man	10/		D42464		4/8/	98	
	\	30. Neme and eddrass of person who	completed cause of death (Ital	m 23a) (Type, Print	1)					
	4	Dr. Sotiere Savo	oulas, MD Rt	. 1, Box	5A1.	Terra Alt	a, West	Virgini	a 267	64
St	ate	04 D-1-49-4 (14-4) D-1-14-1						-0-11		
Regist	rar	APR -	8 1998	The Manual Property	dals.					
DHMH 16 Rev 6/	95		0							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Catherine H. Aydelotte /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5–13–1917 5. Social Security Number If Under 1 Year Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 6 Sex **Funeral** Months Days 1 M 2 X F DE. 215-36-1227 Director Usual Residence of Decedent the Meryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 Yes X No Director De. Sussex Delmar 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 19940 USA Rt. #2 Box 35M permit. Peges 1 and 2 should be filed within 72 hours efter death Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Stetus Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grace Maddox Hearn Everette W. Hearn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Rt.#2 Box 35M, Delmar, De. 19940 Catherine M. Smith, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or St. Stephens Cem. 4-14-98 Delmar, De. 21. Signature of Funerel Servica Licansee 22. Name and Address of Facility Short Funeral Home, Inc. am NI 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the diseese, or complications the caused shock, or heart failure. List only one cause on which aused the death. Do not en Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner physician end the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Physician/Medical USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown signed by by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed After this certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA funeral 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 24 hours efter deet Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cardiying Physician: To the best of my known to beath occurred at the time, dete end place, and due to the cause(s) and menner as stated. [2 Madical Example of the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the date of the cause of 29s. Certifier edical and/or investigation, in my opinion, death occurred at the time, date end ptece, and due to the cause(s) (Check only within 2 29d. Dete signed (Month, Day, Year) 29er Signature and title of certifie 29c. License number D48221

262 Tilghman Rd. Salisbury MD 21801

State

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete fited (Month, Day, Year)

pena MD

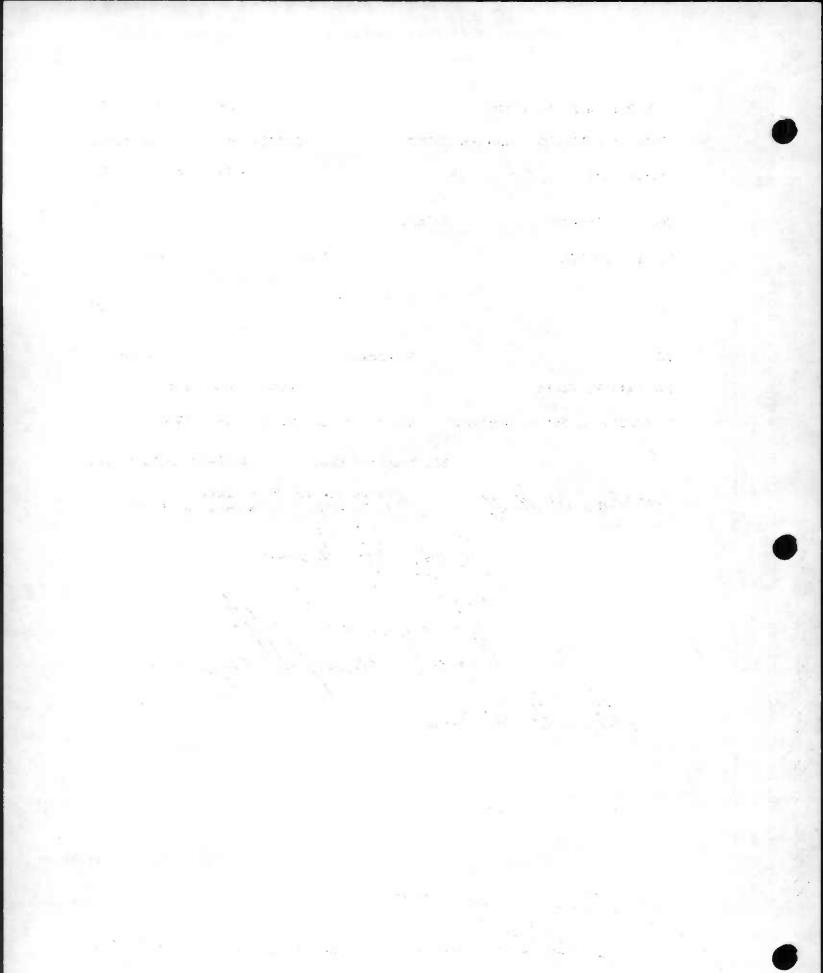
32. Registrar's Signature

Julia Devoleon Randall

Maryland 21215-0020

altimore,

P.O. Box 68760



				State of Mar	-	epartment (Certificate	of Health and I of Death	Mental Hy	rgiene	12	/80
	Physici /Medic		Decedent's Neme (First, Middle, La MARTHA E.					2. Data of De MARC		Year 3	3. Time of Death
	Examir		4e. Fecility Neme (If not institution, giv	AL	76	day) Il Under 1	4b. City, Town, or I.ANHAM (eer Il Under 24 Hrs		PRINC	CE GEOR	GE
16	Funeral Director		5. Social Security Number 6. S 217-30-4494 Usual Residence of Dacedent	ex 7. Age (ln yrs. lest birth Yr	Months D	Pays Hours Min.		ey, Year)	9. Birthpiece Country) MARYLA	e (Stete or Foreign
BRE WITH THE Maryland	28a-f show notified at	Director	10e. Stete 10b. County MARYLAND PRINCE (Oc. City, Town	ER					Inside City Limits 1 XYes 2 No
EIIEN 0020	al', or items 23s or 25s-f sho Examiner must be notified at	by Funeral	10e. Street end Number 2419 KENT VILLAC 11. Marilal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	E PLACE 12. Was Dacedent Event Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:	ar in U,S.	13. Was Deceden) 785 t of Hispanic Origin? (S Cuban, Mexicen, Puerl	pecify Yas or No to Ricen, etc.)		ce - Americen I ck, White, atc.	Indian,
1215-0	ne. hen *netun ne Medicel J	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondery (0-12)	da com <i>pleted)</i> College (1-4or 5+)	(6	fe. DO NOT use r	done during most of wor retired)	rking	16b. Kind of B	usiness/Indust	гу
land 2	d oth	To Be Co	17. Father's Neme (First, Middle, Last) MOSES BRENT	0		DOMESTIC	18. Mother's Ner	me (First, Middla	OUT OF , Meiden Sumen		ME
THA F	Health and Hem 27 is m	T	19e. Informent's Neme/Relationship (DOROTHY ERWIN (DA 20e. Method of Disposition 1 © Burial 2 Cremetion 3	UGHTER)	20b. Plece of D cematery,	2419 KENT disposition (Neme crematory or othe	Treet end Number or Ru C VILLAGE P of r plece)	LACE LA	NDOVER, 20c. Location	MD . 20 City or Town,	785 Stete
MARTH Baltimore,	Department of Important: If any injury or stock.		4 □ Donetion 5 □ Other (Specify 21. Signature of Funeral Service Licen Harry □	Eeese		WM. REES	ddrass of Fecility SE & SONS M		Y, P.A.	LLE, M	D.
	ysician Medical caminer		23a. Pert1. Enter tha disease, or companies of the compan	e. METAB		ACIDO		or respiretory e	prest,	Interior The	proximete ervel Between esat end Deeth
Box 68760,	physicia the bu	an/Medical Examiner	Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest	b. ACUTE	and a supplied to	JAL F/	AILURE			H	DURS
P.O. B	by the ette	by Physician/Me	Pert II. Other significant conditions of					1	tobacco use co	ntribute to the	e cause of death
vision of Vital Records, P.O. Box 6		Completed by	SEVERE ANEN	,				24e. Wes	an eutopsy ormed?	eveilet	autopsy tindings ble prior to etion of ceuse th?
Vital Relicion: The E	ector	Be	POSTOPERATIVE 25. Was case referred to medicel exeminer?				26. Plece of Dea	1 □	one)	1 □ Ye	es 2 No
Division of	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification: To	1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Dey Y		ne ol 28c.	Other: 4 Nursing H Injury et Work? 1 Yes 2 No	28d. Describe	how injury occur	red	
Divi	ours after o		4 ☐ Homicide determined	bullding, etc. (Specify)			City or To			
the Hos	thin 24 hc the Fun mpletely	Medical		velcian: To the best of m liner: On the basis of ex end manner steted	aminetion end/o	or investigation, In	ne time, date end piece my opinion, deeth occu cansa number	rred et the time,	dete end plece, 29d. Dete signe	end due to the	cause(s)
•	≱ ⊬8		> Sao	old hea		12	-4011		3-2		
			30. Nama and eddress of person who o				RON ST #	502 5	SILVERS	PRING	20910 MD

State Registrar 31. Data filed (Month, Dev. Year) APR 0 1 1998

SAADULLAH KHAN MD. 32 Registrer's Signeture
Julia Taindson-Randelle and the second of the second o

State of Maryland / Department of Health and Mental Hygiene

PAUL RUSSELL BITTINGER JR.

Certificate of Death

1. Decedent's Name (First, Middle, Last) Russell Bittinger

2. Data of Deeth 3. Time of Death Dey Month 1998 APRIL 6, 1850 PM

ALLEGANY

Reg. No.

Physician /Medical Examiner

Directo

Funeral

by

Completed

Be

Examiner

Physician/Medical

P

Completed

Be

10

Certification:

Medical

4a Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL

4b. City, Town, or Location of Death CUMBERLAND

4c. County of Death

Funeral Director

worle

r than "natural", or items 23e or 28a-f ehor

Hygiene.

lith and Mental Hygie 27 is marked other r traumetic avant, tr

of Health a

permit. Peges Depertment of Important: If It any injury or or

Physician

/Medical Examiner

> buriel-tran pue

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signed by the

peeu

certificate

this funerel

After

efter deeth. Diractor: Af

24 hours eff Funeral Di detely filled in

To the Within 2

Hospital

director,

Division of Vital or Attending Physician: physician

thet the death certificate be executed

Peges 1 end 2 should be

the Marylend

altimore, Maryland 21215-0020

10a. Stata 10b. County Md

If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) Days Months Hours

8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

218-64-7951 Usual Residence of Decedent

5. Social Security Number

Allegany

10c. City, Town or Location

May 1 1955West Virginia 10d. Insida City Limits

10e Street and Number

Cresaptown 10f. Zip Code

42

1 Yes 3 No

13606 Brant Road

M 2□ F

21502

10g Citizen of What Country? United States

11. Marital Status

1 Naver Married 2 Married 3 Widowed 4 Divorcad

12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give X

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Sales Manager

Auto Parts Business 18. Mothar's Nama (First, Middla, Maidan Sumama)

Paul S. Bittinger Charolette Jones

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 13606 Brant RD, Cresaptown, Md. 21502

Rita Bittinger/Wife

20b. Placa of Disposition (Name of cematery, crematory or other place)

Data 20c. Location - City or Town, State

20a. Method of Disposition

Ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Potomac Mem Gardens 4/11/98 Keyser, WV 22. Name and Address of Facility

21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or implications that caused the death. Do not en shock, or heart failure. Life only one cause on each line.

Boal Funeral Home 111 Church St. Westernport, Md. 21562
enter the mode of dying, such as cardiac or respiratory arrest,

26. Plece of Death (Check only one)

Due to (or as a consequence of)

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

Due to (or as a consequenca of)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco usa contribute to the cause of death?

No No 3 Probably 4 Unknown

24a. Wes an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

Yes 2 No 1 Yes 2 No

25. Wes case referred to medical examinar? 1 X es 2 □ No

27. Manner of Death

1 Natural

Accident 3 ☐ Suicide

4 Homicide

1 Inpatient 5 Pending

ŽCXER/Outpatient 3□ DOA 28b. Time of

40

28c. injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ET1

in auto accide 281. Location (Street and Number or Rural Route Number, City or Town, State) US220 Mega

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

2 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and till of certifier

28

29c. License number O.C.M.E 29d. Data signed (Month, Day, Year) APRIL 8, 1998

ress of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

WARDN LOCKE

Investigation

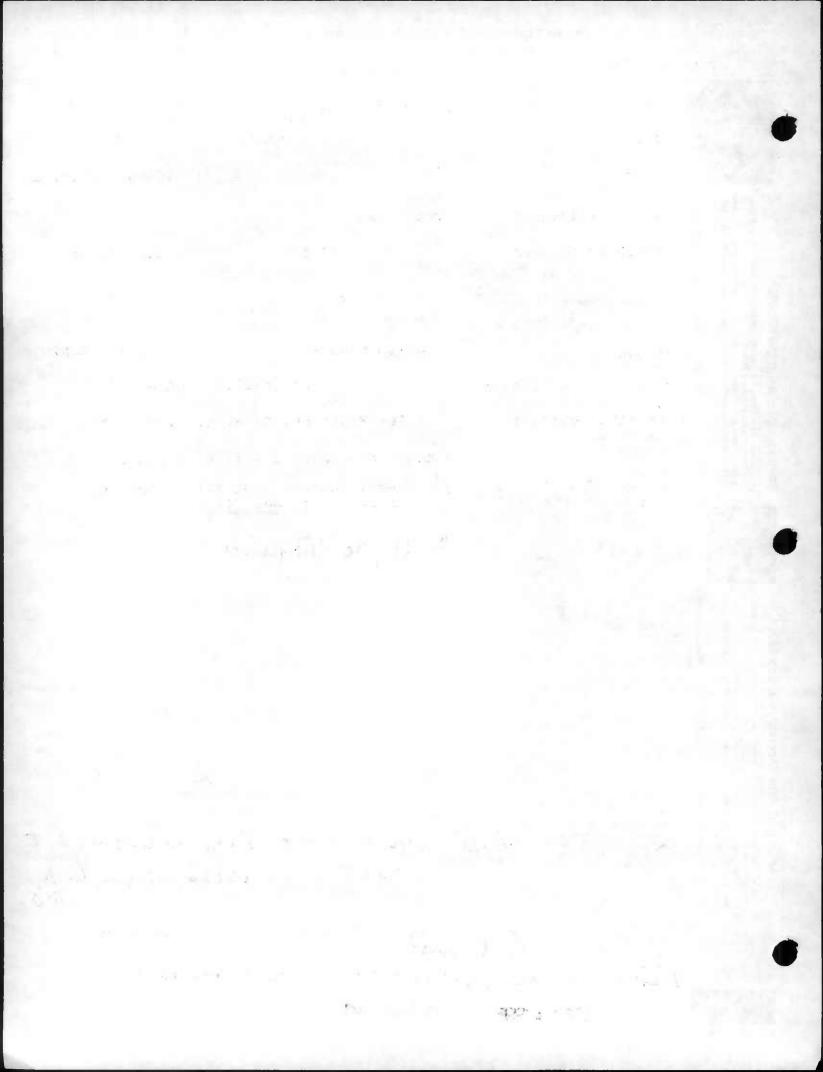
6 Could not be determined

State Registrar

15

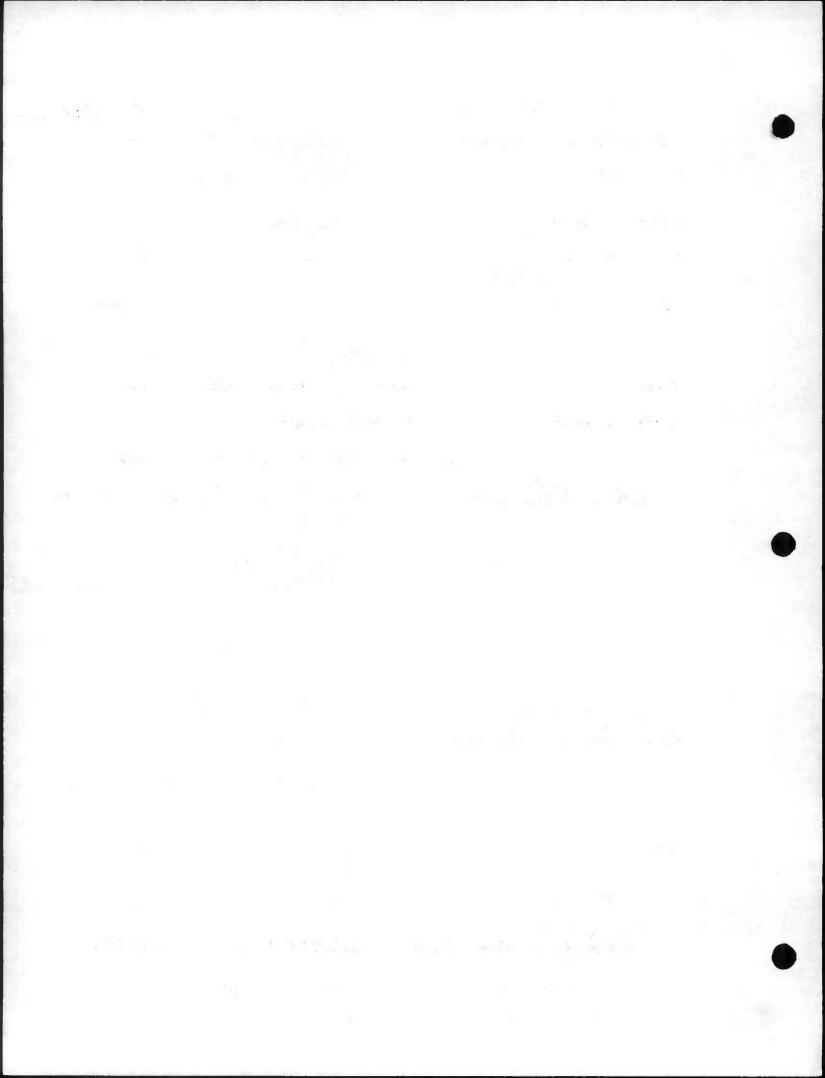
31. Date filed (Month, Day, Year)





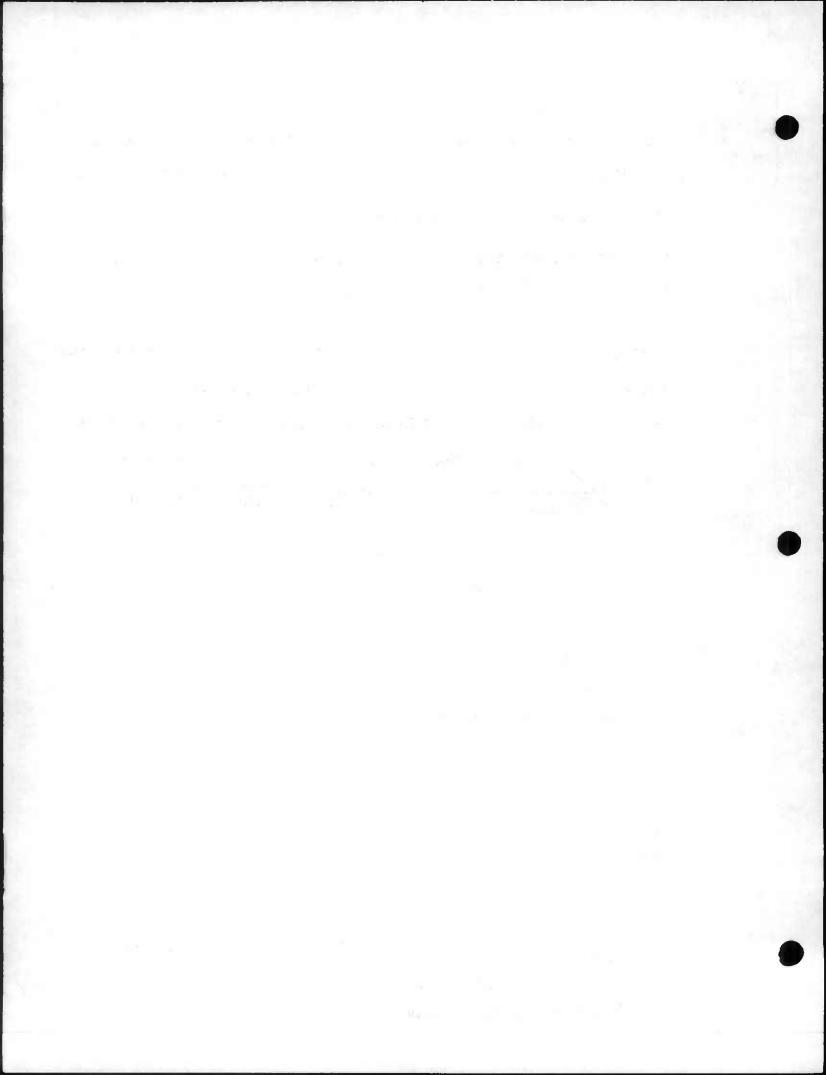
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 2 7 8 2

						Cei	tificate of	f Death		Reg. No.		
Г	Physic	ian	1. Decedent's Neme (First, Middle, La	*					2. Dete of Dee	eth Dev	Yaar	3. Time of Death
	Physic /Medi		DOROTHY LUC	CILLE BUR	KE				April		998	10:35 p.m
	Exami	ner	4a. Facility Neme (If not institution, gir					4b. City, Town, or I				
L			Calvert County N				K Hadas d Va	Prince Fr				
	Funeral Director			1 □ M 2 1 F	(In yrs. lest bi	Yrs.	If Undar 1 Yea Months Days		8. Dete of Birt (Month, De) Jan 4,			plece (Steta or Foreign pland
	ylend wor		10a. Stete 10b. County		10c. City, Tov	vn or Lo	cation				1	Od. inside City Limits
	Mar and a	io	Maryland Calvert				S	t. Leonard	1			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizan of	Whet Cour	ntry?
	23a	la l	2895 Ross Road	l			2	0685		US	SA	
21215-0020	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examinations must be notified at	by Funeral	11. Marital Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forcas? 1 ☐ Yes 2 ☑ N If Yes, Giva Yeer or Datas:			Vas Decedent of Yas, specify Cu I□Yas 2√2 No	Hispanic Origin? (Siben, Mexican, Puertion Specify:	pecify Yas or No- o Ricen, etc.)	14. Rad Ble Specif	ck, Whita,	atc.
2-0	72 ho	Completed	15. Decedent's E (Specify only highast gr.	ducation	16e	. Deced	lent's Usuei Occi	upation	frin =	16b. Kind of B	usiness/Inc	dustry
21	within and the the	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	DO NOT use retir	e during most of wor. red)	King			
12	be filed within itel Hygiene. Id other than 'event, the Merent itel	S	6			hou	sewife	,			home	е
Maryland	2 2 2 2	Be C	17. Father's Neme (First, Middla, Last Percy	")	(Chan	ev	18. Mother's Nen Nellie	na <i>(First, Middle,</i> Elizab		ne) Ve	
IZ	d 2 should th and Men 7 le marke traumatic	2	19e. informant's Name/Reletionship	(Type, Print)				et end Number or Ru				Code
	DE NE		Delores J. Bowen	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			as # 1			.,,	, 01410, 240	0000)
Baltimore,	of He		20e. Mathod of Disposition 1 Disposition 1 Donetion 5 Other (Special Control of Contro		20b. Plece o	of Dispos	sition (Name of netory or other pi		Dete 4-13-98	20c. Location		
alti	permit. Per Department Important: I any Injury o		21. Signatura of Funerel Sarvice Lice			22	. Name end Add	ress of Fecility				
m	80 E 8 8		Dellam B.	Jan-		Ra	ausch Fu	neral Hom	e, P.A.,	Owing	gs, M	D 20736
			23a. Pert1. Enter the diseese, or comshock, or haert feilure. List only	pluetions that caused to	the deeth. Do							Approximata interval Between
	Physician /Medical Examiner	ler	Immediete Ceuse (Final disaese or condition resulting in deeth)	e. Re	f rac	conseq	y Conguence of):	geotnie y dise	Hem	- Fail	me	8 - 12 month
	icete be axecuted physician and s the buriel-transit	Examiner	Sequentially list conditions.	b	Dua to (or es a	conseq	ance of):	n ane	me		1	0-121/1999
Ö,	e axe ian ar uriel-t		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury			•		,				
68760,	sete b shysic the b	Medical	thet Initiated evants resulting in death) Last	C	ua to (or es a	consequ	uence of):					
9 x	E 9 6			d								
Box	eeth ce ettendii I for use	Physician/										
o.	that the de ed by the e deteched f	ysi	Part II. Other significant conditions of					iven in Pert i.	V			the cause of death?
0	thet ned b	by Pt	COFD, Renal	many	Jam	1	/		1/20	′ee 2□ No	3∐ Prol	bably 4 Unknown
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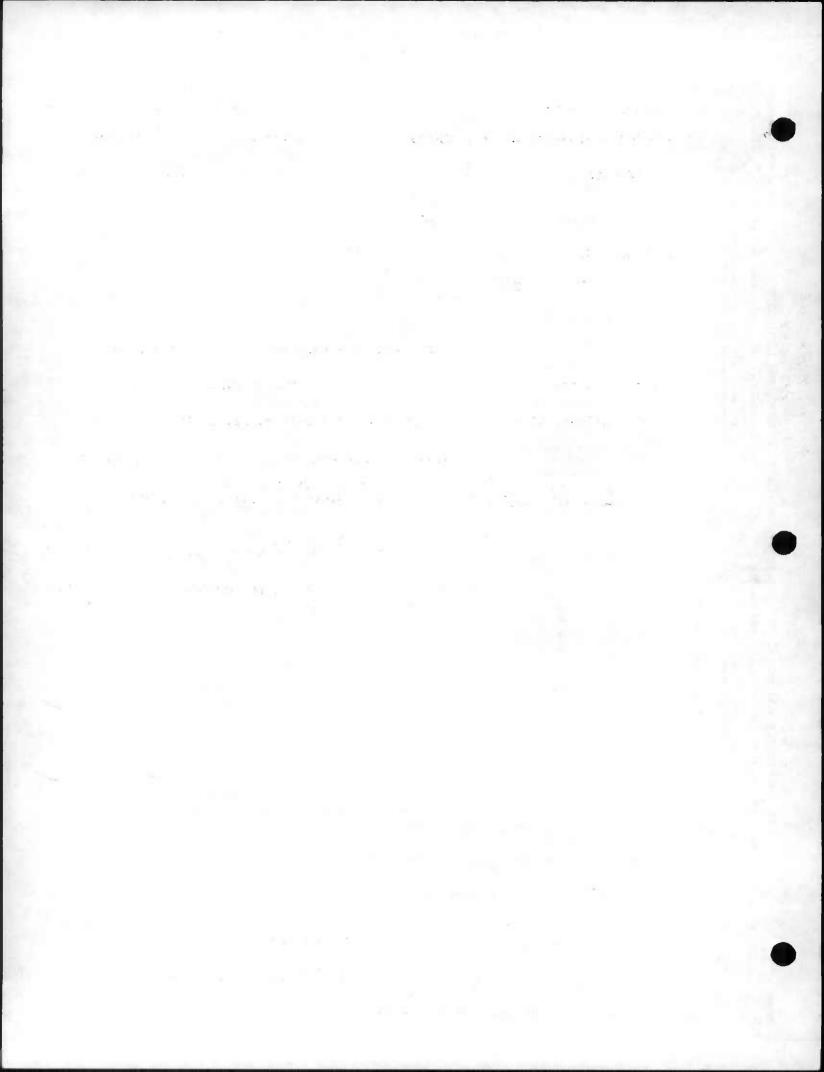
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Deceased Family March Later Deceased Family							Ce	rtificate	of I	Death		Re	eg. No.			
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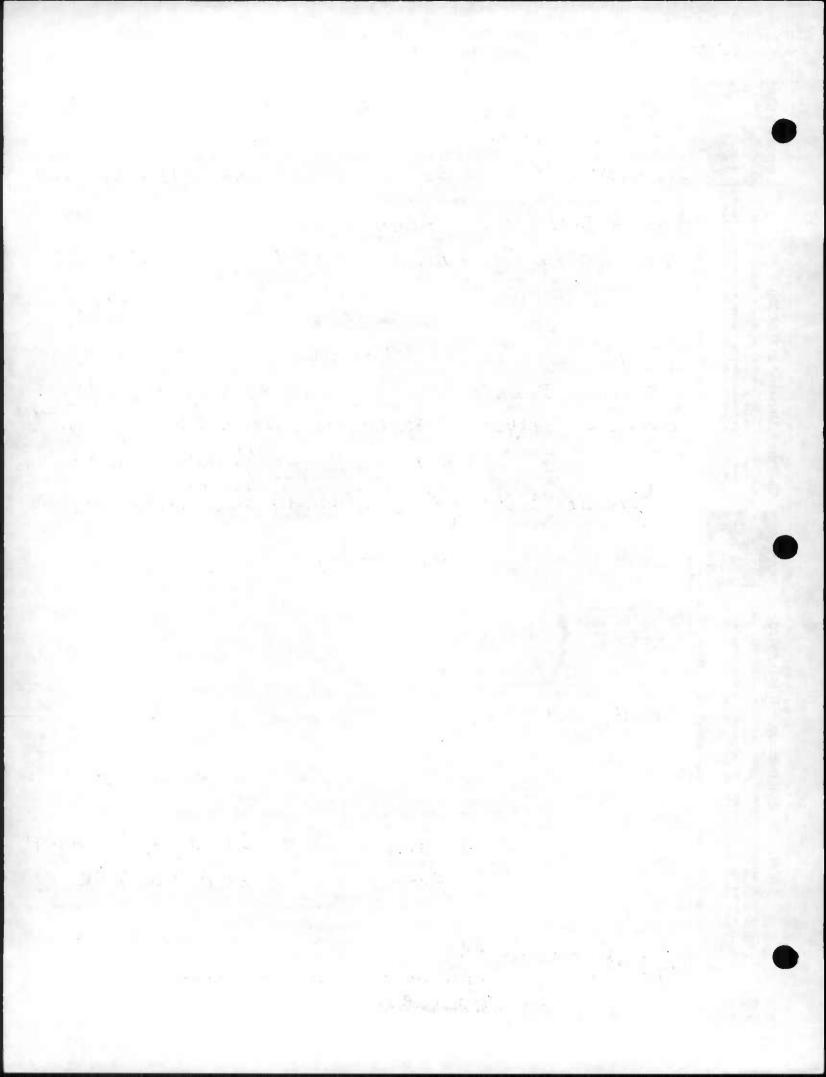
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State of Maryland / Department of Health and Mental Hygiene 9 8 | 2785

							Cert	ificate of	Death		R	g. No.		
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L	Director	0	216-38-7653 Usuel Residence of Decedent			26	1			-	Nov. 2	1,1941	MO	rryland
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Division or Attending	the t	2	2 ☐ Accident investig		4/11/9	8 05	145		Yes 2		ryjed	unga	201	المرادون
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Division Of the Hospital or Attend	within 2x hours are used. To the Funeral Director. After the completely filled in by the funeral Marking Certification.	E :	29h. Signatur and title of certifie	. /	1	^			nse number			9d. Date signe		
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			30. Name and address of person	who complete	ad cause of d	eath (Item 23e)	(Type D	rint)						
		,	JARON	Coch	E M)111 Pe	nn S	street,	Baltin	nore,	Maryla	nd 2120)1	
			31 Date filed (Month Day V	-0-7	32 4						4			
	State	Ì	31. Date filed (Month, Day, Year) APR 1	5 1998	Jelia	erit Signature	Tarda	Ц						
	Registrar		Little T	- 1000										



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Maryland 21215-0020 2 mould be filed within 72 hours at man Mental Hygiens 17 marked other than "natural", or		19a. Informant's No	ama/Relationship (Type, Print)		19b. Mailin	Addrass (S	treet and Number or I	Rural Route Numb	er, City or Town	Stata, Zip Coo	da)
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To the within 2	Mec	29b. Signatura and	titla of certifiar	and mannar	SIGIOU.		29c. Li	icansa number		29d. Data signe	ed (Month, Day	, Year)
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State Registrar

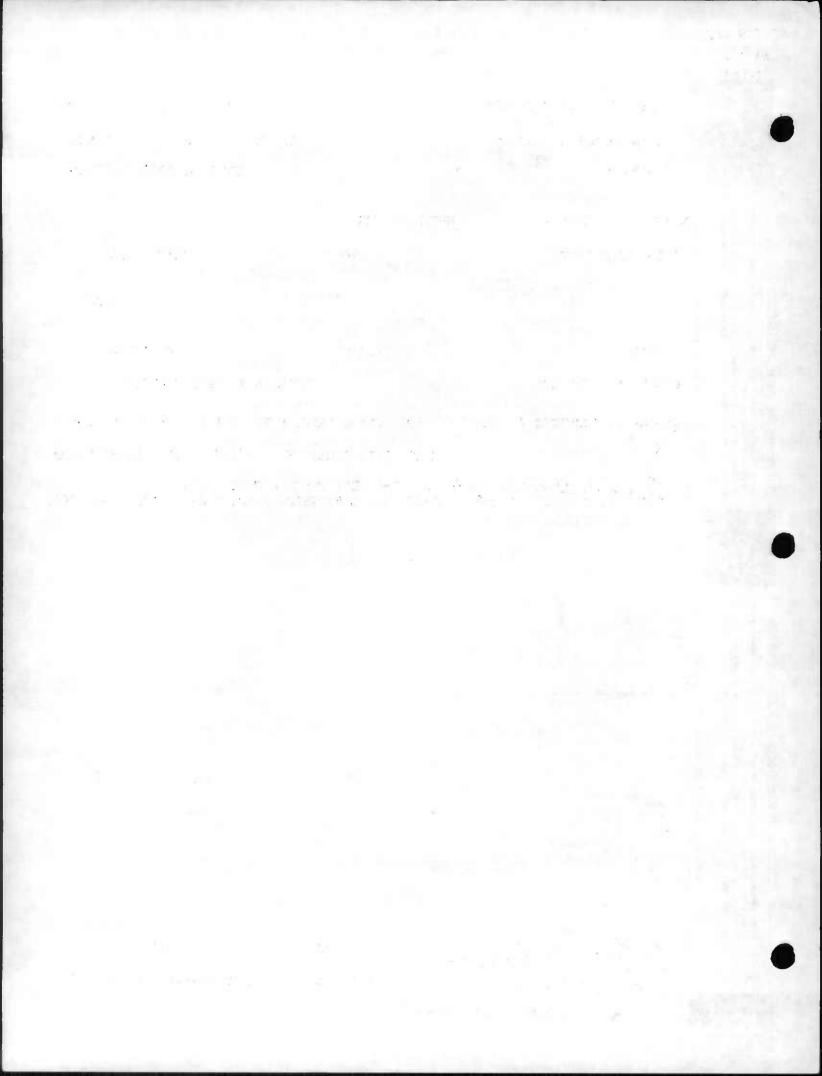
THE DOJE McKing 31. Data filed (Month, Day, Yaar) APR 1 4 1998

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

APRIL 13,1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death CAREY MARGARET 9 1998 Aoril 10:32 am 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Wicomico Nursing Home Salisbury Wicomico If Under 1 Year 8. Date of Birth (Month, Dey, Year) OCT. 11,1898 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthplece (Stete or Foreign Country)
 MARYLAND 1 ☐ M 2 🗓 F Months Days Hours 99 216-09-1126 Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 27 No WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 AMHERST RD. 21801 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, 11. Maritai Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dales: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OFFICE CLERK SHOE STORE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) SIDNEY POWELL MARTHA BETHARDS J. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) EDWIN CAREY - SON 311 AMHERST RD. SALISBURY, MD 21801 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 \(\) Burial 2 \(\) Gremation 3 \(\) Removel from State 4 \(\) Donation 5 \(\) Other (Specify) JOHN'S CEMETERY 4-14-98 FRUITLAND, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List *on*ly one cause on each line. Maria Approximate Intervei Betwe Onset end Death Immediate Cause (Final disease or condition resulting in death) a. Acute myorpromiss Infanct
Due to (or as a consequence of): Ihar. Due to (or as a consequenca of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Lest Antenios de rosis -Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Congestive Hapath Failure 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 √ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No

pue physician s the buriel Box 68760. P.O. á Records. Division of Vital

Physician/Medical þ Completed Be 10 Certification:

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/Medical

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exacting must be notified at

"natural",

permit. Pages 1 and 2 should be filed withir Department of Heelth end Mental Hygiena. Important: If fam 27 is merked other than any injury or other traumatic avant

Physician

/Medical

Examiner

with the Maryland

Baltimore, Maryland 21215-0020

Margaret

he Hospital or Attending Pin 24 hours after death.

The Funeral Director: After the pletely filled in by the funeral

State Registrar

Medical

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🕱 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

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28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Imm., Print)

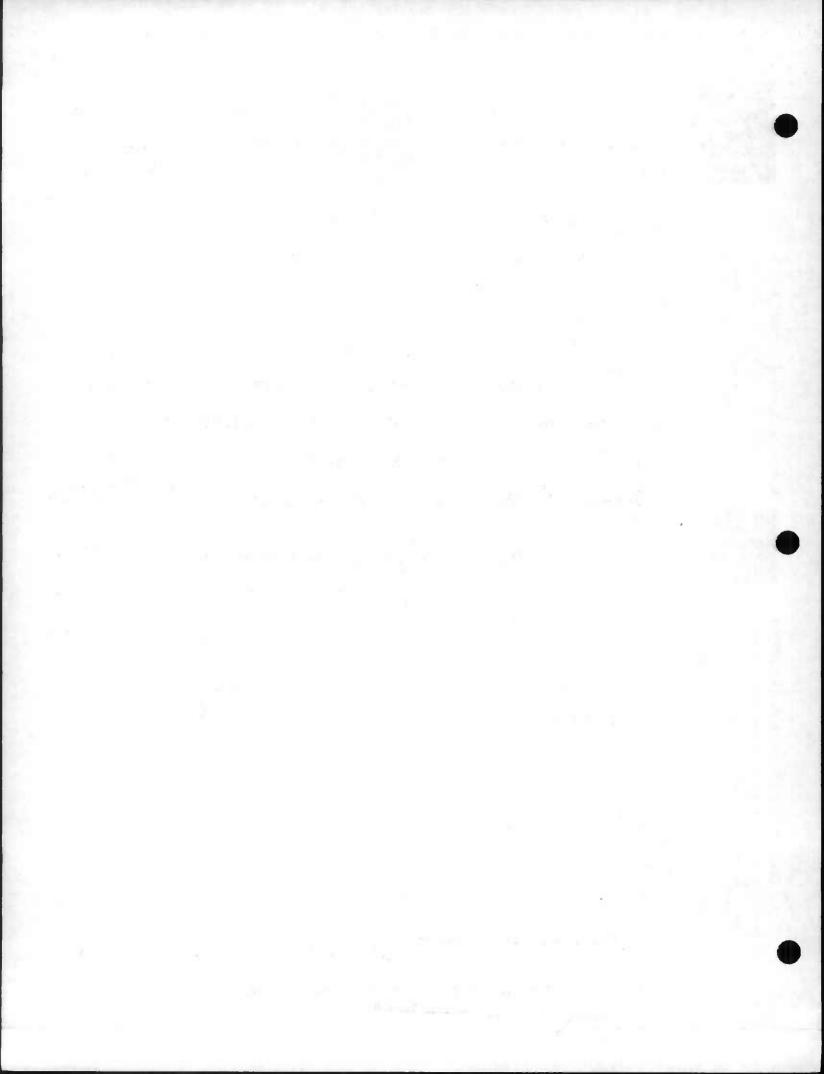
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Federico G. Arthes, MD 1622A Ocean Pines Berlin, Md 21811
31. Date filed (Month, Dey, Year) 32. Registrar's Signature Q 4.44 32. Registrar's Signature

was distribution Problem

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Within 2 To the I



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 23b per M.D. G-758 4/30/98 reb State of Maryland / Department of Health and Mental Hygiene AMEND# 10G CMH 4/6/98 AACO HEALTH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Vest Hagar Dodge 29 /Medical 1998 March 2:14AM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5502 Mallard Lane Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. iast birthday) **Funeral** Birthplaca (State or Foreign Country) 1 ☐ M 2 □ (F Yrs Director 214-52-9999 89 Oct 25 1908 Sweden Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. insida City Limits ns 23e or 28a-f ehov Director 1 ☐ Yes 2 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with United, States 414 Edlon Park $\frac{21613}{}$ 21403 by Funeral Hems . 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner 1 □ Naver Married 2 □ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 5 1 ☐ Yes 2 ☑ No Specify: ₩Widowed 4 Divorced Specify: White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) al Hygiene. Etementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is stjerked oths any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surname) Be August G. Ahlsont 0 Ahlfont Anna V. Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Patricia Melvin (Niece) 414 Eldon Park Cambridge, Maryland 21613-1310 20a. Method of Disposition

1 → Buriat 2 □ Cramation 3 □ Removal from Stata 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Spacify) 4/2/98 U.S. Naval Academy Annapolis, MD 21401 22. Name and Address of Facility ohn M. Taylor Funeral Home, Inc. 21. Signature of Fugeral Service License 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rasptratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Ftnai disaasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last dischore ettending physician for use as the buria Kimans Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? t signed by the 1 Yes 2XXNo 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? s certificate hes b director, page 2 s 1 Yes 2 No 1 Yas 2000 al or Attending Physicien: The safter death.

I Director: After this certificate ed in by the funeral director, pe Be 25. Was case referred to medical 28. Place of Death (Check only one) examinar? 10 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Deter (Specify) 51 m's homes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how tnjury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide cal Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basts of examination and/or investigetion, in my optnion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or within 24 hours aft To the Funeral Di completely filled in

21215-0020

Baltimore, Maryland

State Registrar

B

31. Date filed (Month, Day, Year)

29b. Signature and titla of certifier

Nawas APR 02 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

105 32 Registrar's Stgnatura Fundamental Sura Law doon Random 29c. Licensa number 00050987 29d. Date signed (Month, Day, Year)

Breek Campridge MD 21613

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** Month IVA RUBY ELLIOT /Medical April 8, 1998 6:30 p.m. 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5979 Cranesville Road Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Jan 31, Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 F Hours Months Days 86 Director Maryland 235-22-4822 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location a or 28a-f show Show 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 5979 Cranesville Road 21550 item 27 is marked other than "natural", or itama 23a other traumatic event, the Med cal Exeminer man b USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. Int: If item 27 Is marked other than "natural", or ita 8 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: p Specify. 3 ☑ Widowed 4 ☐ Divorced Yeer or Dates: white Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 7 th Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lewis Van Sickle 2 Luetta Kellv 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Naomi V. Teets/sister 5979 Cranesville Rd., Oakland, MD 21550 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: If its any Injury or ot 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blooming Rose Cem., Apr. 11, 1998 Friendsville, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fasters. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine 3 deroue diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest pue the buriel-trer Due to (or as a consequence of): Box 68760. ettending physiclan I for use es the burie Physiclan/Medical Due to (or as a consequence of) P.O. P been signed by the e should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? page 2 hes After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of the death.

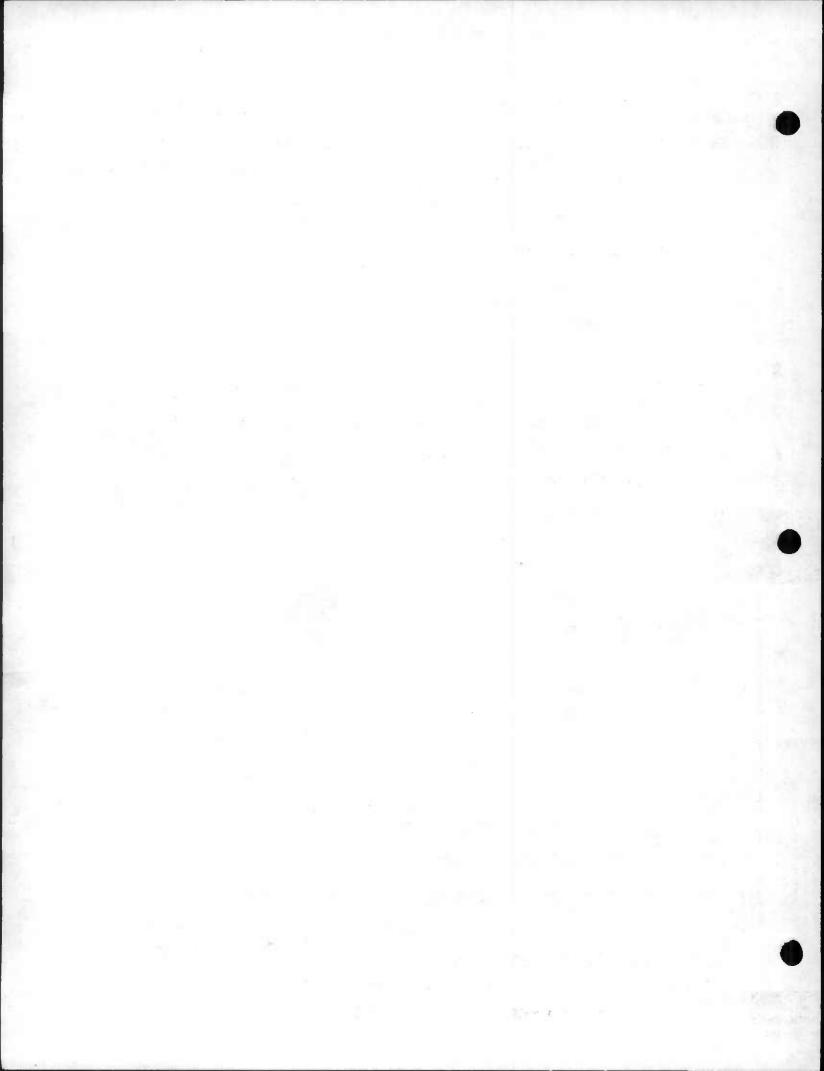
Director: After this certifications Be 25. Was cese referred to-medical 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 2 1 Yes 2 No 5 Hesidence 6 □Other (Specify) 27. Manper of Death 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours of To the Funeral I Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end menner stated. \$ 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) A.E. Mance, M.D.,

3 S. Third St., Oakland, MD 21550

32. Registrar's Signature

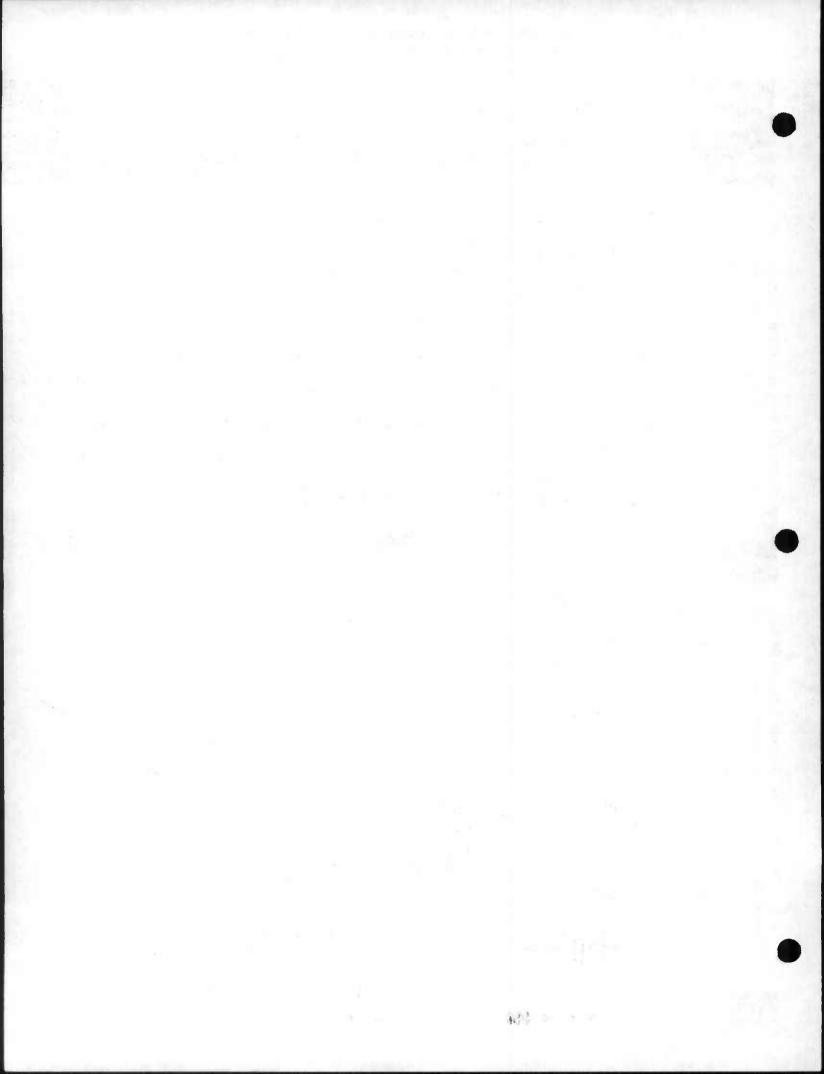
State Registrar

31. Date filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene 3 | 2790

					Certificate of	Death		Reg. No.		
		1. Decedent's Name (First, Middle	, Last)			1:	2. Date of De	ath		3. Time of Death
Physician /Madian		John Hamil	ton FORM	IAN			Month March	Day 31, 1998	Year	5:15 AM
/Medica Examine	_	4a. Fecility Neme (If not institution,	, give street end number)			4b. City, Town, or				J.13 AN
LAGITITIC	1	Garrett County		snital		0aklar	d	Garr	att	
Funeral				(In yrs. last bi	thday) If Under 1 Yee	r If Under 24 Hrs	8. Date of Bir	th I		e (Stete or Foreig
Director	-	705-10-9042 Usual Residence of Decedent	1 <u>M</u> M 2□F	80	Yrs. Months Day	s Hours Min.	(Month, Da Feb. 2	y, Year) B, 1918	Country Maryla	and
show		10a. State 10b. County		10c. City, Tow	n or Location				10d	. Inside City Limit
Bed	0	MD Gar	rett		Oakland					1 X Yes 2 □ N
28 1001	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country	,?
2 4	2	426 South Third	Stroot			21550		•	,	
178.22	era	11. Marital Status	12. Was Decedent E	ver in IIS			necify Ves or No	US 14 Bac	e - American	Indian
f Health and Mental Hygiene. Item 27 Is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Medical Examinet must be notified at TO Re Completed by Entered Disperse.	Funeral	1 Never Married 2 Marrie	Armed Forces?		13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puer	to Rican, etc.)	Blac	ck, White, etc	
0,0	2	3 ☐ Widowed 4 ☐ Divorced	ed 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 Ne	Specify:		Specify	/: LIT-	nite
out E	8	15. Decedent's		16a	Decedent's Usual Occ	upation		16b. Kind of Bu		
and the	Completed	(Specify only highest	t grade completed)		(Give kind of work don life. DO NOT use retir	e during most of wo	rking	TOD. TURIO OF DI	00110000111000	, in y
Hygiene. ont, the Me	Ē	Elementery/Secondary (0-12)	College (1-4or 5+		eld Represe			Insuran	oo Co	
the the		17. Father's Name (First, Middle, L	ast)	1.1	era Represe		me (First, Middle,			•
end Mental la marked of aumatic eve	ď	John Connor				Lula	Louis		tzmill	100
d Merk	0	19a. Informant's Name/Relationsh		401	Mailian Address (Otro					
h en Tar					. Mailing Address (Street					
item 27 li other tra	-	L. Susan Forman	/W1Ie		26 S. Third Disposition (Name of	St., Oak			21550	
		20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation	3 ☐ Removel from Stete	cemete	ry, crematory or other pi	ace)	Dete	20c. Location -	City or Town	n, Stete
ant:		4 Donation 5 Other (Sp.		0akla	nd Cemetery		4/3/98	0akland	, MD	
Department of Important: If is any Injury or once.		21. Signature of Funeral Service D	founsee		22. Name and Add					
. a E a a	4	> Bulle A	LUDONA		Stewart	Funeral H cond St.,	lome Oakland	4 MD 2	1550	
	7	23a. Pert1. Enter the disease, or o	complications that caused t	he death. Do						pproximate
hysician		shock, or heart feilure. List o	only one cause on each line	1.					i In	nset and Death
Medical		Immediete Cause (Final	07777							
xaminer	1	disease or condition resulting in death)	a. CHF						i	Years
.	<u>.</u>		D	ue to (or as a	consequence of):					
nsit night			b. AMI						1	Week
physician and s the buriel-transit	X	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a	consequence of):				į	
burie		cause. Enter Underlying Ceuse (Disease or Injury	c. Ischemi	c Card	iomyopathy				7	lears
ng physicie s es the bu	5	that initiated events resulting in death) Last	D	ue to (or es e	consequence of):				i	
d gnill ge es t										
ettendir for use	2		-						1	
by the e	315	Part II. Other significant condition	a contributing to death but	not resulting i	the underlying cause g	iven in Part I.	23b. Dld 1	obecco use co	ntribute to th	ne cause of deet
d by the ettend eteched for us		Ponel Feilum	o Voore				1 🗆	Yes 2□ No	3 Probat	oly 4 Hhkno
igned it	2	Renal Failur	e, lears							
0.0								an autopsy		autopsy finding
en sig buld b	5 I						porto			letion of cause
s been sig										
hes t	neidillo						10.	Vac 25 No	100	ree 20 No
page 2 s		DE Wassassafarrad I medical						Yes 2 No	1 🗆 Y	′es 2□ No
page 2 s	מ	25. Wes case referred to medical exeminer?	Hospital:		10	ther	ath (Check only o	one)		′es 2□ No
is certificate has t director, page 2 s	200	exeminer? 1 Yes 2 No	Hospital:		ripatient 3 DOA	ther: 4 Nursing H	ath (Check only o	one) denca 6 □Oth	er (Specify)	′es 2□ No
is certificate has been s director, page 2 should To Be Completed	200	exeminer?	28a. Date of Injury	28b.	Fime of njury 28c. Inj	ther: 4 Nursing F ury at ork?	ath (Check only o	one)	er (Specify)	′es 2□ No
is certificate has t director, page 2 s	200	exeminer? 1 Yes 2 No 27 Manuar Death 1 Hatural 5 Pending investiga	28a. Date of Injury (Month, Day	28b.	Fime of njury 28c. Inj	ther: 4 Nursing H	ath (Check only o	one) denca 6 □Oth	er (Specify)	′es 2□ No
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riter death. Virector: After this certificate has the bind by the funeral director, page 2 sertification: To Be Complement	200	exeminer? 1 Yes 2 No 27 Manner Death 1 Manner Store 1 Accident investige 3 Suicide 6 Could no	28a. Date of Injury (Month, Day)	Yeer) 28b.	Fime of njury M 1[ther: 4 Nursing F ury at ork? Yes 2 No	dome 5 Resid	denca 6 Oth	er (Specify) red	
iffer death. Virector: After this certificate has been s in by the funeral director, page 2 should striffication: To Be Completed	Ceruncanon. 10 pe	exeminer? 1 Yes 2 No 27 Manner Death 1 Internal 2 Accident S Pending investige 3 Suicide 6 Could no determin 29e. Certifier Certifying	28a. Date of injury (Month, Day) ation ot be hed 28e. Place of Injury building, etc.	y - At home, fa (Specify)	rime of njury M 28c. Injury M 1[cmm, street, factory, office	ther: 4 Nursing Fury at ork? Yes 2 No	ath (Check only of tome 5 Residue) 28d. Describe I 28f. Location (Chity or Town)	denca 6 □Oth now injury occur Street end Numb vn, State)	er (Specify) red er or Rural R	Route Number,
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inter death. Nirector: After this certificate has been s in by the funeral director, page 2 should striffication: To Be Completed	regical certification. To be	exeminer? 1 Yes 22 No 27 Manne Dean 1 Daniural investige 3 Suicide 6 Could no determin 29e. Certifier (Check only 2 Medical E	28a. Date of Injury (Month, Day) ation of be end 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of e	y - At home, fa (Specify) my knowledge xemination an	ime of njury M 1[imm, street, factory, office do do investigation, in my	ther: 4 Nursing Fury at ork? Yes 2 No time, dete and place opinion, death occurse number	ath (Check only of tome 5 Residue) 28d. Describe I 28f. Location (City or Town), end due to the time,	denca 6 □Oth now injury occur Street end Numb vn, State)	er (Specify) red eer or Rural R	Route Number, ed. e cause(s)
iffer death. Nirector: After this certificate has been s in by the funeral director, page 2 should exitification: To Be Completed	regical certification. To be	exeminer? 1 Yes 22 No 27 Manne Dean 1 Pantural investige 3 Suicide 6 Could no determin 29e. Certifier (Check only one) 1 Certifying 2 Medical E.	28a. Date of Injury (Month, Day) ation of be end 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of e	y - At home, fa (Specify) my knowledge xemination an	ime of njury M 1[imm, street, factory, office do do investigation, in my	ther: 4 Nursing Fury at ork? Yes 2 No	ath (Check only of tome 5 Residue) 28d. Describe I 28f. Location (City or Town), end due to the time,	denca 6 □Oth now injury occur Street end Numb vn, State) ceuse(s) end ma date and place,	er (Specify) red eer or Rural R	Route Number, ed. e cause(s)
free death. Virector: After this certificate has t in by the funeral director, page 2 sertification: To Be Complement		exeminer? 1 Yes 22 No 27 Manue Dean 28 Locident Si Pending investige 6 Could not determing (Check only one) 29b. Signeture end title of cartifier	28a. Place of Injury (Month, Day) 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of a end manner state	y - At home, fa (Specify) my knowledge xemination and	imm, street, factory, officed, death occurred at the d/or investigation, in my	ther: 4 Nursing Fury at ork? Yes 2 No time, dete and place opinion, death occurse number	ath (Check only of tome 5 Residue) 28d. Describe I 28f. Location (City or Town), end due to the time,	denca 6 □Oth now injury occur Street end Numb vn, State) ceuse(s) end ma date and place,	er (Specify) red eer or Rural R	Route Number, ed. e cause(s)
within 24 hours efter death. To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed		exeminer? 1 Yes 22 No 27 Manual Death 28 Accident Sirvestige 3 Suicide Gould not determine 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 30. Name and eddress of person w	28a. Place of Injury Month, Day ation at be 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of e end manner state	y - At home, fa (Specify) my knowledge xemination and.	ime of njury M 1[imm, street, factory, office don't investigation, in my 29c. Lice (Type, Print)	ther: 4 Nursing Fury at ork? Yes 2 No time, dete and place opinion, death occurse number	ath (Check only of the control of th	denca 6 Oth now injury occurs Street end Numb vn, State) ceuse(s) end madate and place, 29d. Dete signe	er (Specify) red eer or Rural R	Route Number, ed. e cause(s)
ifter death. Nivector: After this certificate has the funeral director, page 2 sin by the funeral director, page 2 sertification: To Be Complexition: To Be Complexition:	Medical Columbia	exeminer? 1 Yes 22 No 27 Manne Dean 28 Accident Suicide Good Getermin 29 Certifier Check only 2 Medical E. 29 Signeture end title of cartifier 30 Name and eddress of person w Dr. Thomas Jo	28e. Place of Injury (Month, Day) 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of end manner state the completed cause of deal ohnson, MD	y - At home, fa (Specify) my knowledge xemination and. ath (Item 23a) 311 N.	imm, street, factory, officed, death occurred at the d/or investigation, in my	ther: 4 Nursing Fury at ork? Yes 2 No time, dete and place opinion, death occurse number	ath (Check only of the control of th	denca 6 Oth now injury occurs Street end Numb vn, State) ceuse(s) end madate and place, 29d. Dete signe	er (Specify) red er or Rural R anner es stete end due to th d (Month, Da	Route Number, ed. e cause(s)
within 24 hours after death. To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s Medical Certification: To Be Completed.	Medical Certification: 10 be	exeminer? 1 Yes 22 No 27 Manual Death 28 Accident Sirvestige 3 Suicide Gould not determine 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 30. Name and eddress of person w	28a. Place of Injury Month, Day ation at be 28e. Place of Injury building, etc. Physician: To the best of xaminer: On the basis of e end manner state	y - At home, fa (Specify) my knowledge xemination and. ath (Item 23a) 311 N.	ime of njury M 1[imm, street, factory, office don't investigation, in my 29c. Lice (Type, Print)	ther: 4 Nursing Fury at ork? Yes 2 No time, dete and place opinion, death occurse number	ath (Check only of the control of th	denca 6 Oth now injury occurs Street end Numb vn, State) ceuse(s) end madate and place, 29d. Dete signe	er (Specify) red er or Rural R anner es stete end due to th d (Month, Da	Route Number, ed. e cause(s)



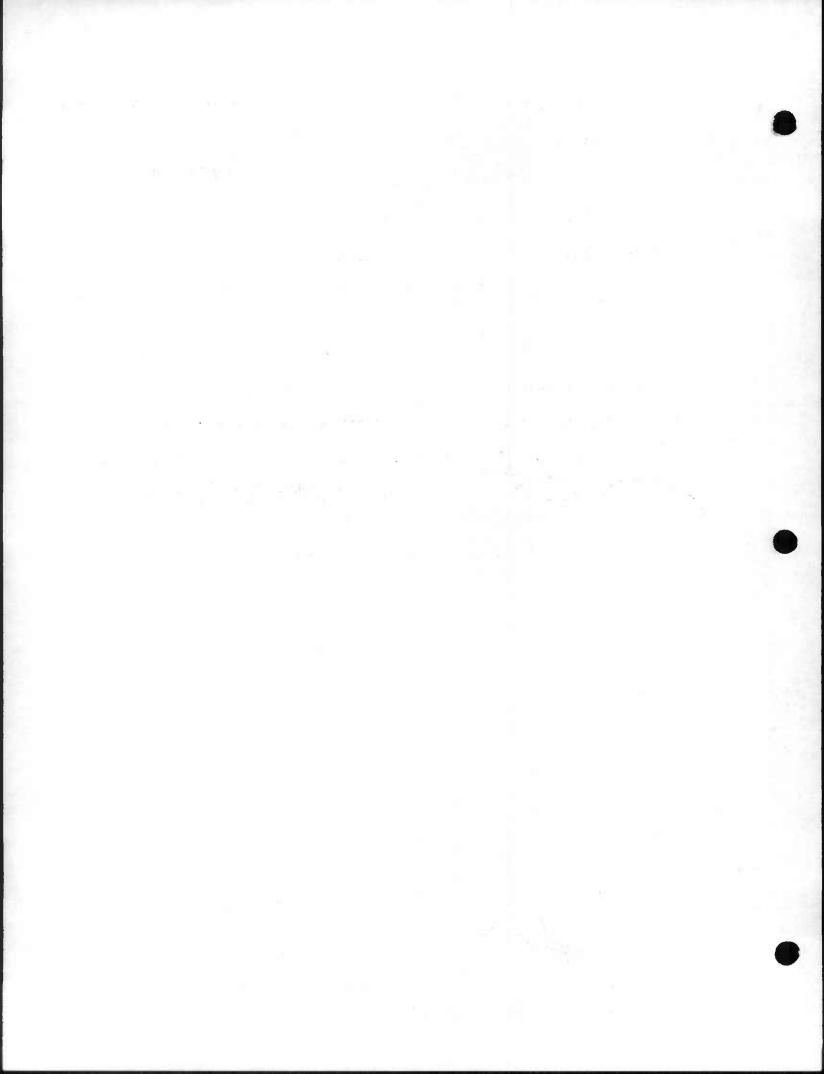
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Thomas Lee Fagans April 1998 604 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 610 Cook Drive Salisbury Wicomico If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) July 1, 1934 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthpiece (Steta or Foreign Country) **Funeral** 1 M 2 F 087-28-2482 63 Yrs Director NC Usuei Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at MD 1 ☐ Yes 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Coda 10a, Citizen of What Country? 610 Cook Drive 21801 U.S. Funeral deeth 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Biack, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after d
Department of Heelth and Mentel hygiene.
Important: If item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Examines. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 WDivorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Coilege (1-4or 5+) Laborer Contractor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Edward Fagans Sarah Blunt 19e. Intormant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Veronica Bryant/stepdaughter 108 Howard St., Hebron, MD 21830 20e. Method of Disposition 20b. Piece of Disposition (Neme of camatery, cremetory or other piece) Dete 20c. Location - City or Town, Stete X□ Buriei 2□□ 4 Dopatton 5 Oth Green Acres Mem Park 4/11/98 Salisbury, MD / (Specify 21. Signature of Funeral Se 22. Neme end Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Part I. Enter the outside, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear labora. List only one cause on each line. **Physician** /Medical Immediata Cause (Finel disease or condition resulting in daath) Examiner Due to (or es e consequence ot): Examiner physician end the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Dua to (or es e consequence of): 80 ettending p ed by the e Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 No 1 Yes 3 Probably 4 Unknown þ been si 24b. Wera autopsy tindings aveilable prior to completion of cause of death? 24a. Was an eutopsy Completed has certificata 1 Yes 1 ☐ Yes 2 ☐ No after deeth.

Director: After this certifica 25. Wes casa reterred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of injury - Al home, tarm, street, fectory, offica building, etc. (Specify) 4 Homicida e Hospital of 24 hours at Puneral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to tha causa(s) and menner es steted.

| Madical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, deta and piece, and due to the cause(s) end mannar steted. 29e. Certifier To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Dete signed (Month, Day, Year) D47637 4-8-98 30. Neme end eddress of person who completed cause of daeth (Item 23e) (Type, Print) Bi State Blud Delmar, MD 21875 3 Inzer/110 32. Registrer's Signeture 31. Deta tiled (Month, Day, Year) APR 091998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** APRIL 8, 12:56 PM EDWARD WHITE GARDINER, SR. 1998 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CHARLES LA PLATA CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**♥** M 2□ F Yrs 72 Director 578-26-5751 MAY 13, 1925 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is merked other than "natural", or items 23a or 28a-f shor traumetic event, the Medical Examiner must be notlined at 1 ☐ Yes 2 No Directo MARYLAND **MECHANICSVILLE** CHARLES 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 14010 EDWARD GARDINER ROAD 20659 U.S.A. Completed by Funeral 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 72 hours efter 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. should be filed within Elementary/Secondary (0-12) College (1-4or 5+) **PRODUCE** OWNER / OPERATOR 6 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h end Mental H Be AGNES COOKSEY WILLIAM PURCELL GARDINER, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14010 EDWARD GARDINER RD, MECHANICSVILLE, MD 20659 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 end 2 st partment of Health en portant: If Item 27 Is r y Injury or other traus DORIS E. GARDINER/WIFE Baltimore. 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donaflon 5 Other (Specify) Department of Important: If any Injury or ST.PETER'S CEMETERY APR 13,1998 WALDORF, MARYLAND from 5 Li Other Licensee 5 ☐ Other (Specify) 21. Signatur THE HUNTI FUNERAL HOME, INC. M00053 MARK G. P.O. BOX 156, WALDORF, MARYLAND 20604 **BROHAWN** 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting In death) /Medical **Examiner** Examiner Attanding Physician: The law requires that the death certificate be executed buriel-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical the Due to (or as a consequence of) signed by the atte Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24a. Was en eutopsy performed? peen hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No teseme director 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural s effer dea. 1 □ Yes 2 □ No 2 Accident To the Hospital or Attar within 24 hours efter des To the Funeral Director completely filled in by th 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 101009 ulu MI P.O. BOX 2539 LA Grange Avenue 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Bu

State

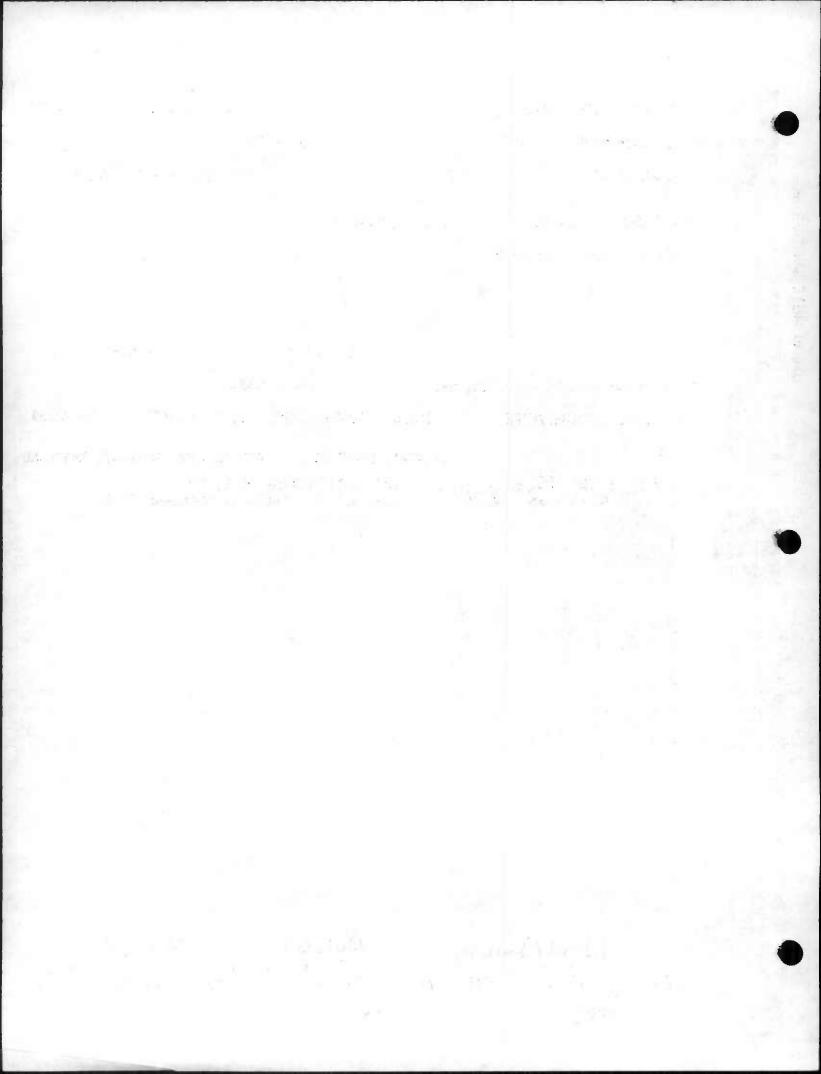
Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4 1998

Julia Davolson Roylett



State of Maryland / Department of Health and Mental Hygiene 🏻 🤉 ITEMS: #5 PER FH G762 8-3-98 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month **CEPHAS** GRAY APRIL 9,1998 03:30a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 80 Yrs. Months Days Hours Min. (Month Day, Year) May 5, 1917 5. Social Security Number 9622 9. Birthplace (Stete or Foreign Country) Maryland **Funeral** 1□XM 2□ F 154-18-9162 Director Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show 1 Yes 2 No Director Maryland | Lusby Calvert 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12709 Sounding Road 20657 USA Funerai daath 12. Was Decedent Ever in U.S. Armed Forces?

**Marker Scill No 1942—
If Yes, Give Year or Dates: 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - Americen Indian, Black, While, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours efter on and of Health and Mantal Hygiena.
Int: If tem 27 is marked other than "natural", or item iny or other traumals event, the Medical Experience iny or other traumals event, the Medical Experience. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (fv only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) Custodian Board of Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harry Gray Martha Kent 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Gray/Wife P.O. Box 162 Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABuriel 2 Cremetion 3 Removal from State permit. Pege Depertment of Important: If any Injury or once. Maryland Veterans' Cem. 4/15/98 Cheltenham, MD 4 ☐ Donallon 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 9. 1451 Dares Beach Rd. Prince Frederick, MD 20678 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cordio-**Examiner** Due to (or as a consequence of): Examiner The law requiras that the death certificate be executed bunei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): physician s the buriel P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of): esn ate has been signed by the e page 2 should be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yas 2 | No 3 | Probably 4 | Unknown Hy potry Roid Records, by Be Completed 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Wes an autopsy performed? Spoliston certificate 20 No 2 No Division of Vital or Attanding Physician: director. 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours completely filled Hospitai 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician 2 C 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1 gratis Dr. Dhiren H. Shah, M.D., Prince Frederick, Maryland, 20678

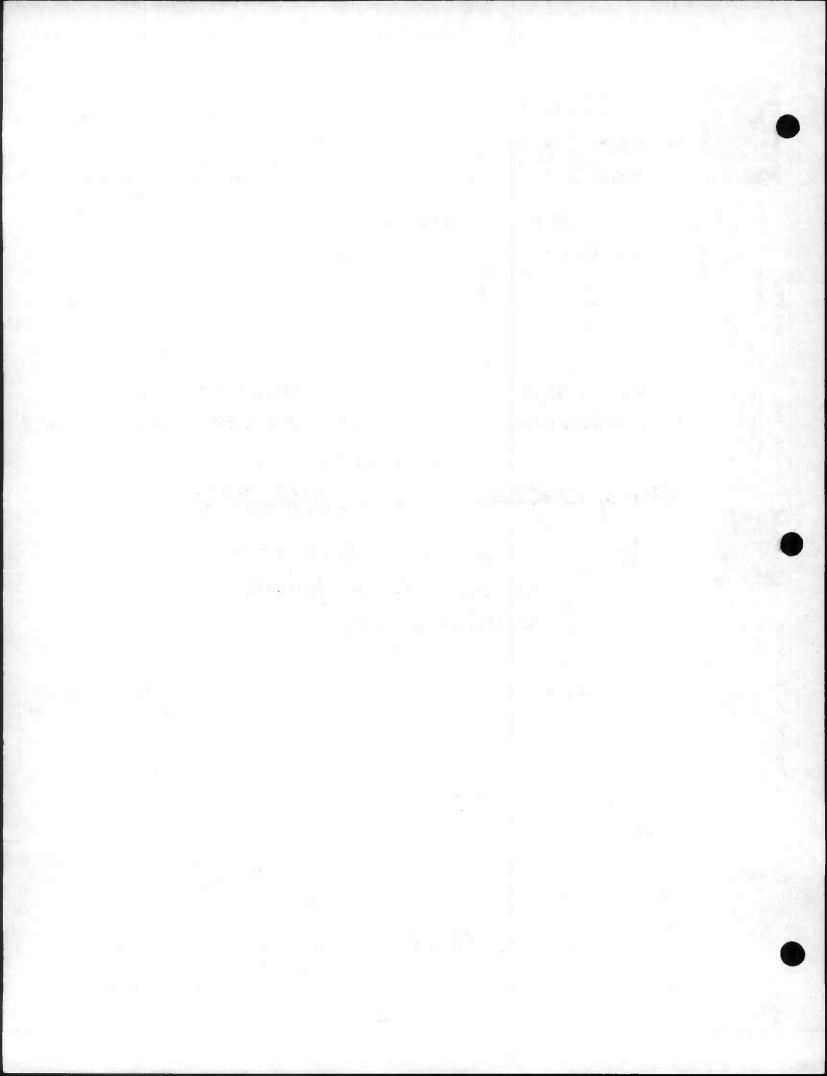
32. Registrar's Signature .

DHMH 16 Rav 6/95

State Registrar 31. Date filed (Month, Day, Year) APR 13

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 2 7 9 4 State of Maryland / Department of Health and Mental Hygiene

						ertificate o	f Death		g. No.							
Г	Physic	ian	1. Decedant's Name (First, Middle, Last,)				2. Date of Death Month	Day	Year 3	. Time of Death					
	/Medi		PURNELL M. HARD	ESTY					9 1998	Toal	2321					
	Exami		4a. Facility Name (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County	of Death						
			ANNE ARUNDEL MEDIC	AL CENTER			ANNAPOLI	S	ANNE	ARUNI	DEL					
П	Funeral		Social Security Number 6. Security Number		rs. last birthday	/) If Under 1 Year Months Day					(Stete or Foreign					
	Director		213-12-6472 Type In the second	DM 2□F 87	Yrs.	Monario Day	3 TIOUIS WIIII	JAN. 17								
	land mow		10a. State 10b. County	10c.	City, Town or I	ocation				10d.	Inside City Limits					
	Mary	ò	MARYLAND ANNE ARU	NDEL.	ANNAPOL	TS					1X Yes 2 □ No					
	the 28s	9	10e. Street end Number			10f. Zip Code		10	og. Citizen of W	that Country?						
	A S	Funeral Director	200 B HILL TOP LAN	E ADT 207		2140			gi oktori ii							
	fie 2	era		12. Was Decedent Ever in	1 U.S. 13			Specify Ves or No-	14 Bace	US - American I	ndian					
_	r Her	Ē	1 Never Merried 2 XMarried	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specify Co	f Hispenic Origin? (S uban, Mexican, Puer	to Ricen, etc.)		k, Whita, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
21215-0020	filed within 72 hours efter death with the Maryland hygiene. ither than "natural", or Herns 23a or 28a-f show ither than Practical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X N	o Specify:		Specify:	BI	ACK					
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pu	should be filed nd Mental Hygi marked other imatic event, II	Be	17. Father's Nama (First, Middla, Last)	2 1201			18. Mother's Na	me (First, Middle, M	leiden Sumem	Θ)						
Maryland	2 should be f and Mental is is merked of raumatic eve	To	WALTON S. HAR	DESTY			CARRI	E TURNER								
an	d 2 should th and Mer 7 is marke traumatic	•	19a. Informant's Name/Ralationship (Ty	pe, Print)	19b. Mai	ling Address (Stre	et end Number or Ri		City or Town,	Steta, Zip Co	de)					
	22 m		DOROTHY HARDESTY (WIFE)	200	B HILL TO	OP LANE AC	OT. 207 A	NNAPOLI	S. MD.	21403					
Baltimore,	of Healt of Healt item 2 r other		20a. Method of Disposition	208	. Place of Disp	osition (Name of emetory or other p	lece)		Oc. Location -							
Ĕ	Pages nent of I int: If ite		1 □xBurlal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		S MEM. GA		4/2/98 A	NNAPOLI	S. MD.						
alt	교원론들.		21. Signature of Funeral Service License					, , , , ,		0, 115.						
m	Deper Impor any ir															
			23a. Part1. Enter the diseasa, or compli	cations that caused the de	eath. Do not er	321 WEST	ST. ANNAI	POLIS, MD	21401	. An	proximeta					
	Physician		23a. Part1. Enter the diseasa, or compli shock, or heart failure. List only or	ne ceuse on each line.	1	,	^		- 1,	Inte	ervel Between set and Death					
	/Medicai		Immediate Ceuse (Final	Murca	50.0	I T.	oto ~	tion								
	Examiner		disease or condition resulting In death)	Due to	(or as a conse	anaboo of):	macro.	, , , , ,								
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	ifficate be executed g physician end es the buriel-fransit	Examiner	Sequentially list conditions.	Que to	(or as a conse	equance of k	101141									
ó	an er		Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or Injury	Cardio	W (a	withy										
68760,	nysici he bu	edical	that Initiated events resulting in death) Lest	Due to	(or as a conse	ence of):										
	E 000		resulting in death / Lest		,	V /				i						
Box	death cert e attendin ed for use	an	d							1						
	dea ne att	Sici	Pert II. Other significant conditions con	tributing to death but not i	esuiting In the	underlying cause (given In Part I.	23b. Did tob	acco use con	tribute to the	causa of death?					
P.O.	that the de led by the a deteched	Physician/N						1 □ Ye	s 2DNo	3 Probabl	y 4□Unknown					
	es that igned b	by														
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Vita		Be C	25. Was casa rafarred to medical				26 Place of Dec	ath (Check only one		1010	3 21,140					
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	al or A s after if Direct	Certification:	4 Difficios	building, etc. (Spe	iciry)			City or Town,	Stete)							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	Iclan: To the best of my k	nowledge, daal	th occurred at the	time, date and place	, and dua to the car	use(s) and mar	nner as stated	ı.					
	n 24 n 24 ne Fu	edicai	one) 2 Madical Examin	er: On the basis of exami and menner stated.	nation and/or Ir	nvestigation, in my	opinion, death occu	irred at the time, da	ta end place, a	nd due to the	cause(s)					
	Vithi To the	Σ	29b. Signature and title of certifier	1/ 1/	, A	29c. Lice	nse number	29	d. Date signed	(Month, Day	Year)					
			Denn	Mall	mo		141216		3-19	-92						
			30. Nama and addrass of person who co	mplated causa of death (II	tem 23a) (Type	, Print)	204 11	act C	+,	10						
			Dennis M.	Hall.	M.D		Anna M	Nic . ~	11	21401						
	Sta	te	31. Data filed (Month, Day, Year)	32. Registrar's Sig	nature			(· · · · · ·	1.44							
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State of Maryland / Department of Health and Mental Hygiene 8 | 2795

			Ce	ertificat	e of	Death		Reg. No).			
الكبيها	1. Decedent's Neme (First, Middle, Las	t)					2. Data of D	Death		Voca	3. Time of	Deeth
Physician /Medical	Patricia Anne	Hartz					Apri	1 1:		Yeer 1998	4:13	3 am
/Medical Examiner	4a Facility Name (If not institution, give					4b. City, Town, o	r Location of Dea		. County		7020	, GIII
	3755 Glebe Meado					Edgewat			1		Arunde	
Funeral Director	5. Sociel Security Number 6. Security Number 410 48 1973 Usuel Residence of Decedent	9X 7. Age (In) ☐ M 2☑ F 67	rs. lest birthdey Yrs.	Months	Deys	If Under 24 Hi Hours Mi		Dev. Year	1930	9. Birthpl Count	laca (Steta o try) TN	r Foraigr
Pue ≹ ■	10e. Stete 10b. County	10c.	City, Town or L	ocation			4			10	0d. Inside Cit	ty Limits
and ahory	MD Anne Aru	indel H	Edgewate	er							1 🗆 Yes	2 🗓 No
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Pa 22	11. Marital Stalus	12. Wes Decedant Evar in	1 U.S. 13.	. Was Dece			Specify Yes or N			e - America	an Indian,	
to Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner natural plus of the To Be Completed by Funeral Director	1 Navar Marriad 2 Married 3 Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Datas:		If Yes, spe 1 ☐ Yes		an, Mexican, Pue Specify:	(Specify Yes or Norto Ricen, etc.)			ck, Whita, a		
out of the second of the secon	15. Decedent's Ed (Specify only highest grad		16e. Deci	edent's Usu e kind of wo	el Occup	oation during most of w d)	orking	16b. K	Ind of Bu	usiness/Ind	lustry	
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permit. Pages 1 and 2 Department of Health important: if item 27 i any injury or other tr. 2008.	20a. Method of Disposition 1 🖾 Burial 2 □ Cremetion 3 🖼 4 □ Donetlon 5 □ Other (Specify	Removal from State	b. Plece of Disp cemetery, cri alvary (ametory or o	other ple	ce)	Dete 4-18-98	M		City or To		
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Physician /Medical Examiner	Immedieta Causa (Finel disaesa or condition resulting In deeth)	e. Canu	0	\sim	an						Onsat end I	
deeth certificete be executed te attending physicien and ad for use as the buriel-transit sician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediata ceuse. Enter Underlying Ceuse (Disease or injury	b. Dua to	o (or es e conse	equence of):	:					 		
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that the deeth cert ed by the attendin deteched for use ? Physician/N	Pen II. Omar eignineant conditions of	ntributing to deem but not	resulting in the	undenying o	ause gr	ven in Part I.			2 No		bably 4	
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The law ste hes page 2							10	Yes 2	No.	10	Yes 2□	No
certificate rector, pag	25. Wes cese referred to medical					26. Plece of D	eeth (Check only	y ona)		1		
Physician: this certific ral director, TO Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpetie	ent 3 D	ON ON	205.	Homa & Re		6 □Oth	er (Specify	y)	
g Physical distributions on To	27. Manner of Deeth	28e. Dete of Injury (Month, Dey Yeer	28b. Time Injury	of :	28c. Inju Wo	ry et rk?	28d. Describ	e how Inju	ry occur	red		
To the Nesptial or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	1 Neturel 5 Panding 2 Accident Investigation 3 Suicide 6 Could not be 4 Homlcide datarmined		it home, ferm, s	М	1	Yes 2□No	28f. Location City or 7	(Street e own, Stet		ber or Rura	I Route Num	iber,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in Medical Cert	29a. Certifiar Cartifying Phyone) Check only 2 Medicat Exam	raician: To the best of my inar: On the basis of exam er of manner stated.	knowledge, dee Inetion end/or i	th occurred investigation	et tha ti n, in my o	me, data and pla opinion, daeth oc	ce, end due to th curred et the time	ne ceuse(s e, date er	i) end ma id plece,	annar as si end due to	eted. the ceuse(s	;)
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D	30. Nama and addrass of person who o					MD						
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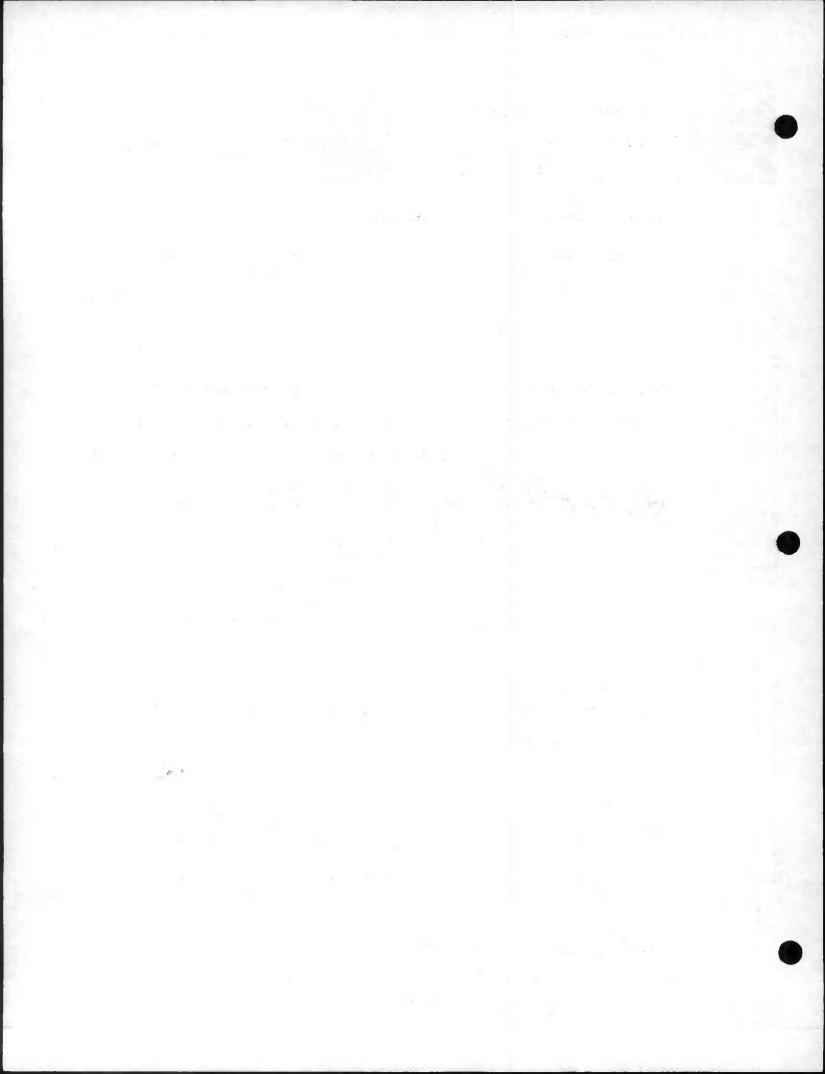
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer 1:30 PM April 8, 1998 tion of Deeth 4c. County of Deeth **ELDRED** CLEVELAND HTLL. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 333 North Park Drive Salisbury Wicomico If Under 24 Hrs. 5. Sociel Security Number if Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F Months Deys Hours Min. Yrs. Director 212-03-5452 5/11/10 Virginia Usuel Residence of Decedent the Maryland 10a. Stete 10h County 10c. City, Town or Location ehow 10d. Inside City Limits r than "naturel", or items 23s or 28s-f ehor the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 333 North Park Drive 21801 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Heelth end Mental Hygiene. Int: If Item 27 Is marked other than ' Irry or other traumatic event, the Ma Elementery/Secondery (0-12) College (1-4or 5+) Painter Painting 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edward Cleveland Hill Maude Ellen Marshall 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Nagel/Daughter S. Park Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cametery, crematory or other place)
Goodwill Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Suriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Depertment of Important: If any Injury or once. 4/10/98 Pocomoke City, MD 4 ☐ Donetion 5 ☐ Other (Specify) co of Juneral Servica Licanus 22. Name end Address of Fecility Holloway Funeral Home 501 Snow Hill Rd., Salisbur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, lock, or heart failure. List only one cause on each line. 301 Snow Hill Rd., Salisbury, MD 21804 Approximete intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel MINS (pKO) (OV BSCULM CORLAPSO diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner pK 18535 CAR DIAC physician end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): YRS. CARONNEL DU ABLEN DOLSEASE Physician/Medical Due to (or es e consequence of): 80 ŏ signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? PAST PEMMENT ATRIM CONTRACTIONS 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been si 24e. Wes en eutopsy performed? Completed C. O. P. D. hes 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner?

1 Yes 2 No 26. Plece of Death (Check only one) å Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidenca 6 Other (Specify) e this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: Attending P er deeth. After 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident or Attend efter deeth Director: 6 Could not be determined 3 Suicide Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homlcide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) (N Cungary 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) x10005105 SALISBARY. 40

Registrar

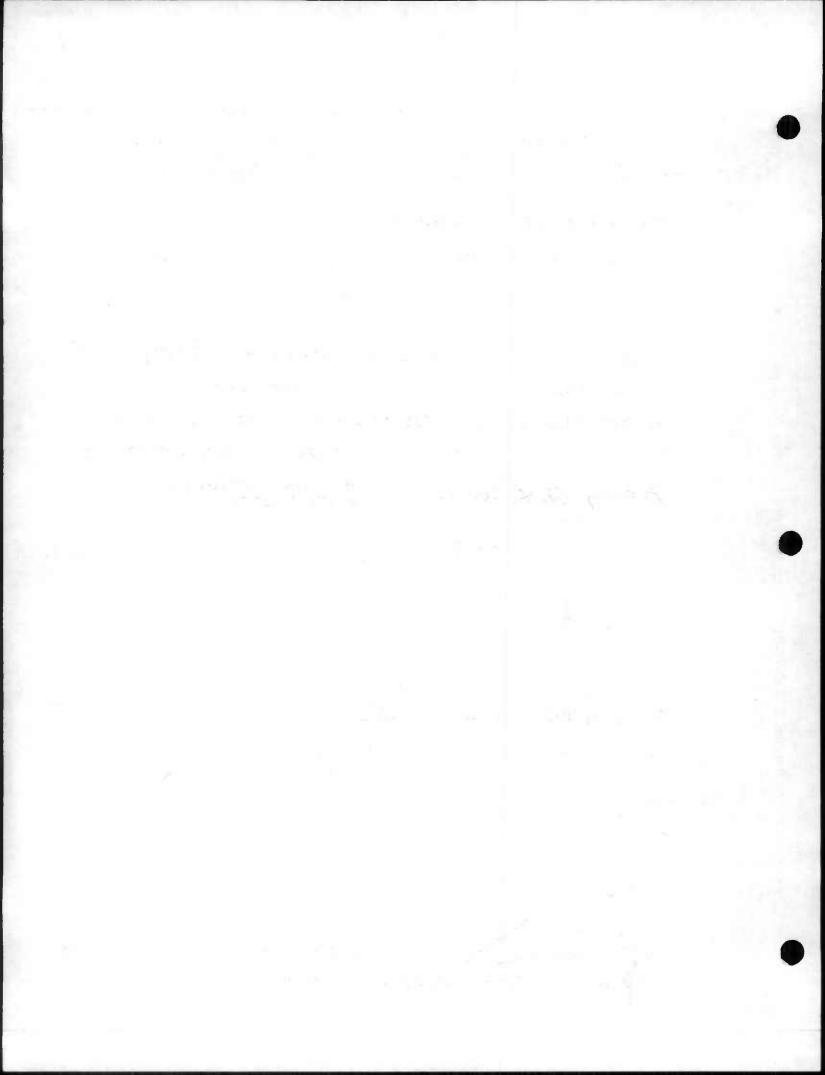
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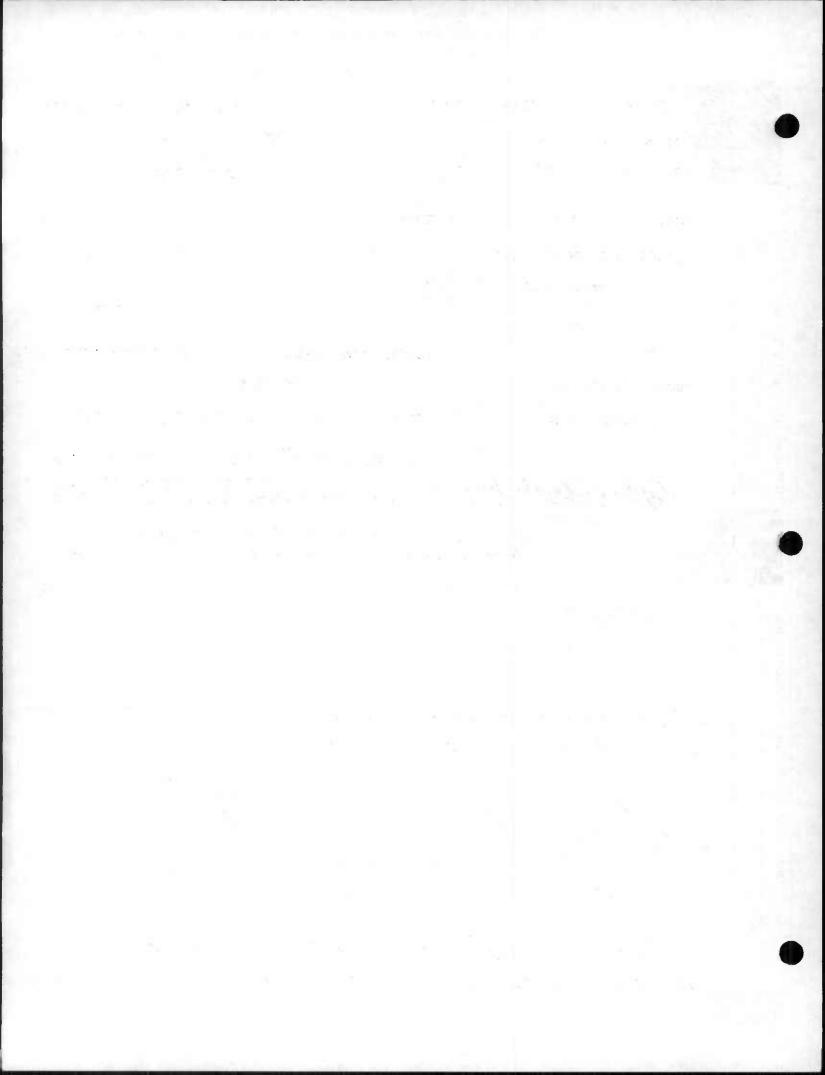
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	AMEND#	5	7 4/1/98 CMS AACO HEALTH	arylario		ficate of	Death	, ,	eg. No.		
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1	Funeral Director		579 66 2097 1₩ 2□F 66	ge (In yrs. la		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day MAY 15	, Year)		ace (State or Foreign
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE ARUNDEL 10e. Street end Number		Town or Loca	tion					d. Inside City Limits 1 Ñ Yes 2 ☐ No
020	72 hours after death with the Maryla "natural", or Nerns 23a or 28s-1 show idical Experience mant be notified at	by Funeral Dir	701 GLENWOOD STREET APT. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Pes 2 Divorced	Evar in U,S		2140	Ilspanic Origin? (Span, Mexican, Puerto			e - America ck, White, e	n Indian,
and 21215-0020	be filed within 72 ho tel Hygiene. d other than "natur event, tre Med cal	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 12th 0 17. Father's Name (First, Middle, Last)		(Give kir life. DO	NOT use retired	during most of work MINSTRATO 18. Mother's Name	R o (First, Middle, i	16b. Kind of Bu GREATER HOSPITA Maiden Sumam	sout Sout	uatry
nore, Maryland	Pages 1 end 2 should in ont of Health and Men int: If Item 27 is marked ary or other traumatic.	To	AMOS JOHNSON 19a. Informent's Neme/Relationship (Type, Print) ANGELA RICHBURG (DAUGHTER) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Pla	7716 E	MERSON	BERDINA and Number or Flun ROAD HYAT ROED	el Route Numbel	, MD . 20 20c. Location -	784 City or Tow	m, Stata
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee → Harry 13, £ac	se	22. N WM •	ame and Addres	ss of Facility & SONS MO	RTUARY,	P.A.		
	Physician /Medical Examiner)r	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Finel disease or condition resulting in death)	DA	Do not enter	cutz	g, such as cardiac (or respiratory arr	est,	1 1	Approximate Interval Between Onset and Death
ox 68760,	certificate be executed iding physician end ise as the bunel-transit	Physician/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last		es a conseque						
ds, P.O. Box	requires that the death cert seen signed by the ettending hould be deteched for use a	by	Part II. Other significant conditions contributing to death b	4046	2015	~		1 🗆 Y	es 2 No	3 ☐ Probe	the cause of death?
Record	has t	Completed	Szizurza port	00	AT	Mars	3 T	24a. Was a perfori	med?	avai com of de	re autopsy findings liabla prior to poletion of cause eath?
on of Vital	g Physician: er this certific neral director,	To Be	25. Was case referred to medical exeminer? 1 Yes 2 No Hospital: 1 Pagatic Manner of Death 1 Naturel 5 Pending (Month, Da	ry 2	R/Outpatient 8b. Time of Injury	3 DOA Oth	4 LI Nursing Ho	me 5 Reside	ence 6 Oth)
Division	deat deat ctor: y the	l Certification:		c. (Specify)		, factory, office		28f. Location (Si City or Town	n, Stete)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 2□ Madical Examiner: On the basis one and manner st. 29b. Signature and title of certifier	examinetio	edge, death oo n end/or inves	29c. License	pinion, deeth occurr e number	ed at the time, d	euse(s) and ma ate and place, of 9d. Date signed	end due to t	the cause(s)
	Sta	te	30. Name and address of person who completed cause of c DR. CAPUTO 139 OLD SOLOMO 31. Date filed (Month, Day, Year) 1998 32. Registr	NS IS		DAD ANNA	POLIS, MD.				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						C	ertificate	of	Death			Reg. No.				
	Dhuaia		1. Decedent's Name (First, Middl	e, Last)							2. Date of Dea		Year	3. Tima of Deeth		
	Physic /Medi		RUSSELL	CALVIN	J	OHNSON					APRIL		1998	8:00 AM		
	Exami		4a. Facility Name (If not institution 11306 HOLLY SI						NANJEM	IOY	ocation of Death	4c. Cour CHAR	ity of Death LES			
	Funeral Director	ı	5. Social Security Number 220-16-8018 Usual Residence of Decedent	6. Sex 1½ M 2□ F	7. Age (In)	yrs. last birthda Yrs.	Months D	ear ays	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, De MAY 25	, Year) , 1926	9. Birth	place (State or Foreign ntry) YLAND		
	land wa		10a. State 10b. County		10c.	City, Town or	Location						1	10d. Inside City Limits		
	Sa-f sh	ctor	MARYLAND CHARI	ES	N	ANJEMO	Ž.							1 ☐ Yes 2€ No		
	23a or 2	Funeral Director	10e. Street and Number 11306 HOLLY SI	PRING ROAD			10f. Zip Co 2066					10g. Citizan o				
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. 'Astural', or items 23s or 28s-f show or other traumetic event, the Medical Exactives insulable notified.	by	11. Marital Status 1 ☐ Never Married 2版 Man 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Dece Armed Fo 14 Yes If Yes, Gin Year or D	rces? 2 No /e	1946– 1947	3. Was Decadent If Yes, specify 1 ☐ Yes 2 ☒			in? (Spe Puerto	ecify Yes or No- Rican, atc.)	14. R	aca - Ameri lack, White, hity: BL			
5-0	72 hc	Completed	15. Decaden (Specify only highe	t's Education st grade completed)		(Gi	cedent's Usuai O	lone	during most	of work	ing	16b. Kind of	Business/In	dustry		
121	within ana. than	dE	Elementery/Secondary (0-12)	College (1	l-4or 5+)	life	DO NOT use n	etire	d)			TONEC	CONTE	PRICTION CO		
	Hygie Hygie Ther	00	11 17. Father's Nama (First, Middle,	Last)		CON	STRUCTIO	DΙΝ			(First, Middle,			TRUCTION CO		
lan	ould be filed with Mental Hygiena. arked other than atic event, the M	To Be	SAMUEL C. JOHNS	SON					ANNIE				,			
Maryland	nd 2 should alth and Men 27 Is marke r traumatic		19a. Informant's Name/Relations SARAH JOHNSON		_		ailing Address (Si					EMOY,		0662		
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: if item 27 is any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cametery, c	sposition (Neme of rematory or other HURCH CE	r pla		-	Date /15/98	20c. Location		own, State ARYLAND		
Balti	Departm Departm Importar any Inju		21. Significant of Funerel Sarvica	ORNTON		L HOM	E, P.A.									
	Physician /Medicai Examiner	her	23a. Part1. Enter the disease, or shock, or heert feilure. List Immediate Cause (Final disease or condition resulting in death)	PR. CARI	03A 6	BLE HOPATHOO (or as a cons	EART & S' A Sequence of):	A	ng, such as c 77ACI CE	ardiac d	or respiratory ar 2-6 he being	rest, urs b	fore	Approximata Interval Between Onset and Death 7 years		
Box 68760,	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											77.013		
	death	sicle	Pert II. Other aignificant condition	na contributing to de	eath but not	resulting in the	underlying caus	a giv	ven in Part I.		23b. Did t	obacco use d	contribute t	o the cause of death?		
P.0	that the death cert ed by the attendin detached for use	Physiclan/	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. Hypercholes terrolemia, Hyperuricemia History of Concestive Heart Failure										23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown			
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Re	sician: The law certificate has b lirector, page 2 s	E									1 🗆 Y	as 2 No		☐ Yes 2☐ No		
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of V	S 00 0	To	examiner? 1 Yas 2 No	Hospital: 1 ☐ I	npatient 2	2 ☐ ER/Outpat	ient 3 DOA	Oth	ner: 4 Nurs	sing Ho	ma 5 PResid	lenca 6 🗆 O	ther (Specia	(y)		
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Division	al or Attendil s after death. Il Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 1 determ	not be ined 28e. Place building	of Injury - Ang, etc. (Sp.	t home, farm, ecify)	street, factory, of	fica			28f. Location (5 City or Tow	Street and Nur m, State)	n <i>ber</i> or Run	al Route Number,		
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State of Maryland / Department of Health and Mental Hygiene

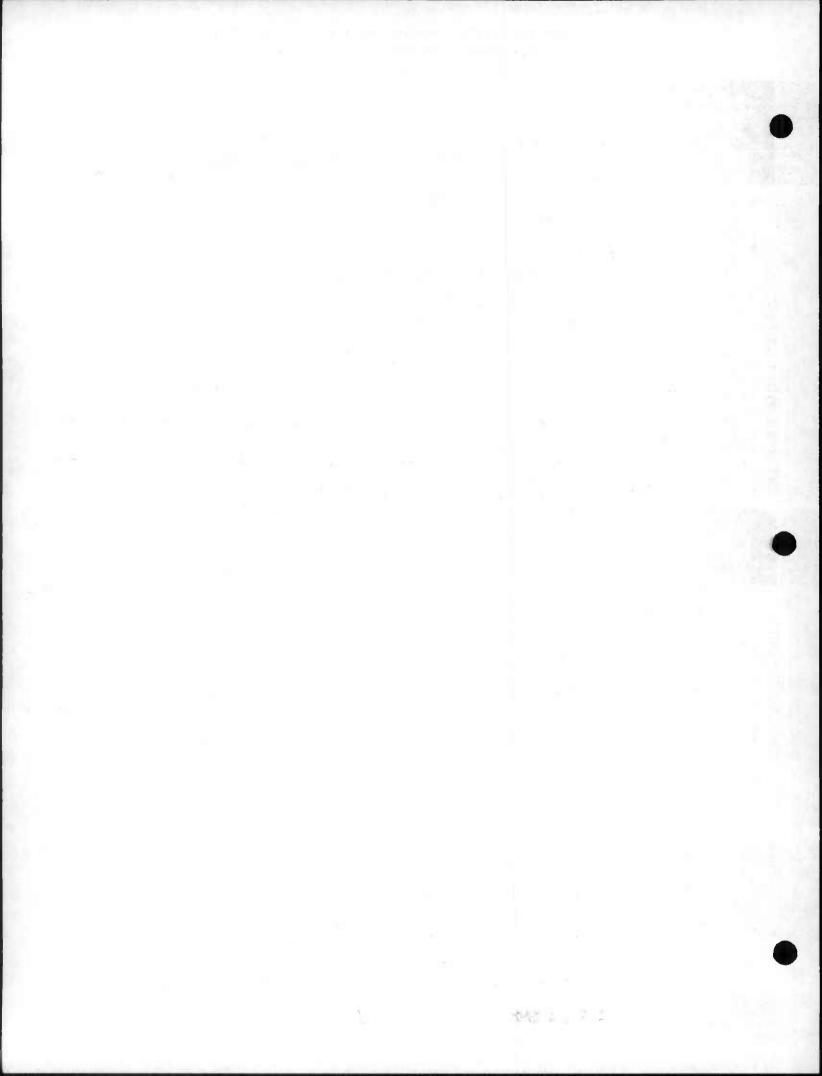
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State of Maryland / Department of Health and Mental Hygiene 8 2800

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	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	4935 Under	rwood Ro	oad				21550		109.01	USA	outiny :			
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State of Maryland / Department of Health and Mental Hygiene

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0,	Physician and Axabician and Ax	Examiner	23a. Pert1. Enter the disea shock, or heert failure immediate Cause (Finei disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause, (Disease or injury	_		ebr Due		onsequ	ence of):						Inierval Between Onset and Deeth
Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	Cause (Diseese or injury that initiated events resulting in deeth) Last	ĺ	d	Due f	o (or as a co	onsaque	ance of):						
, P.O.	ires that the de signed by the i d be detached	by Physic	Pert ti. Other significant co	nditions o	ontributing to d	eath but not		the und		ven in Pert I.	_				bably Unknown
Vital Records,	The law requate hes been page 2 shoul	Be Completed b	25. Wes case referred to m	edicai						28 Piera	T Deeth	24a. Wes perfo		of of	ere autopsy findings eilable prior to mpietion of cause death?
>	5 0 0	ToE	exeminer?		Hospitei: 1 🗆	inpatient	2□ER/Out	patient	3 DOA OI	hor: X			dence 6 🗆 O	her (Specia	(y)
Division of	De fe		2 ☐ Accident ir	ending nvestigation	1	of Injury th, Day Yea	r) 28b. Ti	ime of jury	28c. inju Wo M 1	ryat rk?]Yes 2 □ No		28d. Describe I	now Injury occu	irred	
Divi	ital or Att	Certification:	3 ☐ Suicide 6 ☐ 0 4 ☐ Homicide	could not be letermined	200. Piece	of injury - / ing, etc. (Sp	At home, fen ecify)	m, stree	et, factory, office		2	28f. Location (3 City or Tox		ber or Run	al Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Ma- one)	dical Exan	niner: On the b	best of my asis of exan ner steted.	knowledge, nination and	deeth o	occurred et the ti estigetion, in my o	opinion, deeth	plece, e occurre	ed et the time,	dete end plece	, end due t	o tha cause(s)
	To With	41	29b. Signetura and title of c	nd	GM.	HUS	9	7	Type: Licens	940			29d. Data sign	d (Month,	S &
	10		30. Neme end eddress of pe					Туре, Рі З	o 3 11	0 HO	58	ROAD	ND.	206	25
	Sta Registr		31. Dete filed (Month, Dey,		4 1998	Registrar's S	igneture Sauce	work	ardalf						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1 Decedent's Neme (First Middle Last) 2. Dete of Daath Day **Physician** VIOLA 6, LAYFIELD 1998 1630 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecilify Neme (If not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore 8. Date of Birth (Month, Dey, 9/6/18 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Months Deys Hours Min 214-10-7360 79 Yrs. Director Connecticut Usual Rasidence of Decedent with the Manylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Wicomico Delmar Maryland 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 6 the Medical Examiner numbe 31734 Melson Road 21875 USA 238 death Funeral Rems ; 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - American Indien. 11. Marifel Status Bleck, White, etc. hours efter 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 Navar Married 2 XMarried altimore, Maryland 21215-0020 natural', or 1 Yas 2♥ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 end Mentel Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Domestic Seamstress/Homemaker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 1 and 2 should be Clifford L. Austin Julia Brainard 19b. Melling Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) permit. Peges 1 and 2 s
Department of Health er
Important: If Item 27 Ia
eny Injury or other treu Margaret Wheeler/Daughter 9405 Rum Ridge Rd., Delmar, MD 21875 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Deuriel 2 Cremetion 3 Removel from State 4/10/98 Pocomoke City, MD Melsons Cemetery 4 Donetion FOTOther (Specify) Funeral Service License 22. Name end Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

11. Enter the disease, or complications that a stand the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

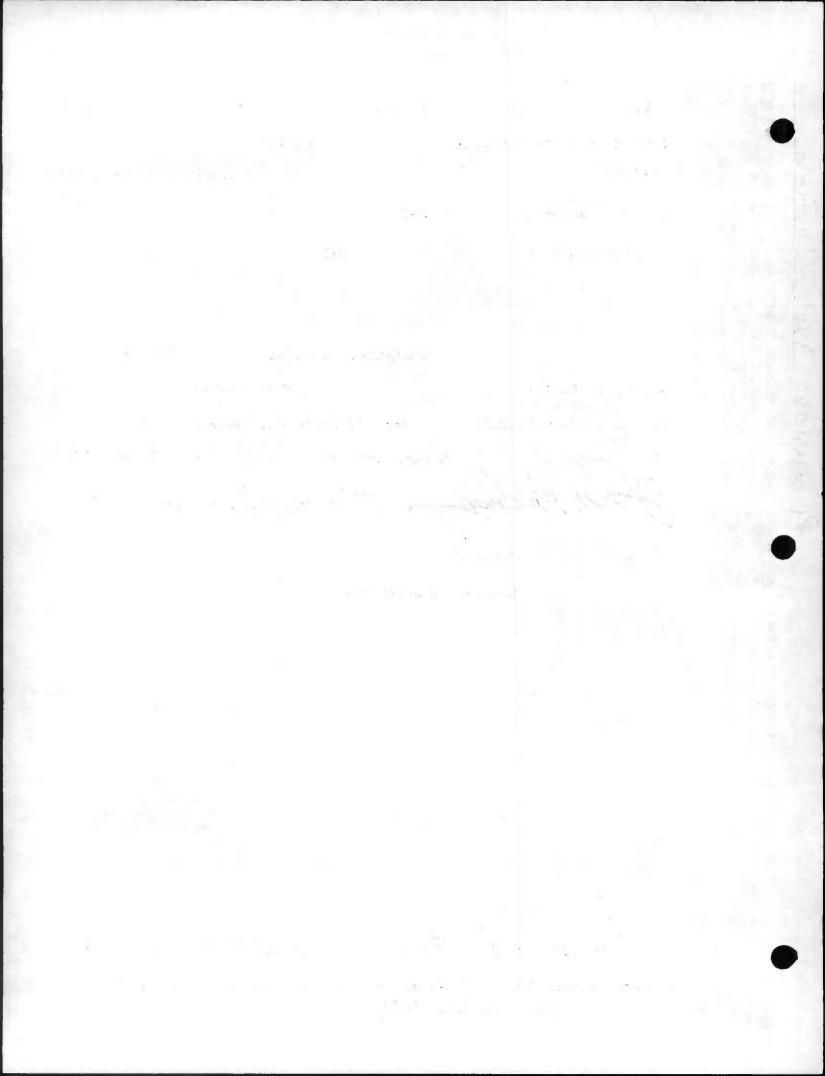
Appropriate the mode of dying, such as cardiac or respiratory errest,

Appropriate the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onsat end Deeth **Physician** Immediefe Ceuse (Final disease or condition resulting In death) /Medical Pneumonia Examiner Due to (or as e consequence of) Examiner Recurrent Ovarian Cancer The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediata ceuse. Enter Underlying Ceuse (Diseese or Injury fhef initieted events resulting in deeth) Las1 Due to (or es e consequence of) pue physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Were europsy findings available prior to 24e. Wes en eutopsy performed? Completed peen completion of ceuse of deeth? certificate has 1 Yas 2 0 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of finjury 28c. fnjury et Work? Certification: After 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No n 24 hours efter death.

Ne Funeral Director: A
pletely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edicai 29a. Certifier 🗺 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. pletely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 29b. Signature and fifla of certified 29d. Date signed (Month. Dav. Yaer) 29c. Licanse number 1998 30. Nema and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 2401 W. Belvedere Avenue Elizabeth Sebree, MD Baltimore, MD 21215 33/ Aggistras Signeture Pardalf 31. Dete filed (Month, Day, Year) State APR 091998

Registrar **DHMH 16 Rev 6/95**

4. Known as



State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Year Laurette A. McClellan April 1, 1998 12:00 P.M. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Crofton Convalescent & rehabilitation Ctr. Crofton Anne Arundel if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 1 M ZXF Days 95 Yrs. 105-07-8999 April 26,1902 New York Usual Residence of Dacadant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits XX Yes 2 □ No Director Maryland | Anne Arundel Crofton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2131 Davidsonville Road 21114 USA Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Completed by Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elamantary/Secondery (0-12) Musical Instrument College (1-4or 5+) 12th Office Worker Store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Arthur Grenzebach Barbara Berghammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Wilson/ Daughter 1905 Marconi Circle Annapolis, Maryland 21401 20b. Place of Disposition (Nama of camatary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4-2-98 Alexandria, Virginia 21. Signature of Junaral Service Licensee George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in daath) Delevel Dua to (or as a consaquance of): Examiner Sequentielly list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initieled events rasulting in deeth) Last Dua to (or as a consequence of) Physician/Medicai Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 10 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of causa of daath? Be Completed 24e. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 000 Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No Invastigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicide † Cortifying Physician: To the best of my knowledga, daath occurred at the time, dete end place, and due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai 29b. Signature and title of ceg 29c. Licansa number 29d. Data signed (Month, Day, Year) MM 30. Nema and address of person who completed causa of death (Item 23e) (Type, Print)

1413 Annapoles Road #106 ochenton MD 21113

State Registrar

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31. Data filed (Month, Day, Yaak)

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APR 03 1998

Sidhu

32. Ragistrar's Signatura
This Davidson-Randale

Funeral

Director

filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

. Pages 1 and 2 should be file mant of Health and Mental H-tant: If Itam 27 Is marked out:

nt of Health a if Itam 27 is or other trai

permit. Page Department of Important: If any Injury or

Physician /Medical

Examiner

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for use as

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director.

funeral

filled in by the

To the Hospital c within 24 hours at To the Funeral D complataly filled

Hospital or Attending Physician: The law requires that the death certificate be assecuted 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

P.O. Box 68760.

Records,

Division of Vital

th and Mental Hygiena. 7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, it a Medical Experient must be notified at

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time = E th Month **Physician** 1998 5:15 m GEORGE LEE MURRAY MARCH 26 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FAIRFIELD NURSING HOME CROWNSVILLE ANNE ARUNDEL If Undar 1 Yaar if Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number Birthpiace (State or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ M 2□ F Yrs. Director 218-14-2108 Usuai Residance of Decedent MARCH 15 1917 MARYLAND 81 the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified as once. 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g Citizen of Whai Country? Funeral 1209 CARRS ROAD 21401 US 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritai Status 14. Race - Amarican Indian, Black, White, atc. 1 Nevar Married 2 ☐ Married Saltimore, Maryland 21215-0020 BLACK 1 ☐ Yes 2 No P Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Induatry Coilege (1-4or 5+) Elementary/Secondary (0-12) CARE TAKER HOLLY BEACH FARM 3rd. 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme) Be GEORGE L. MURRAY SR. MAMIE CURRY 2 19e. informant's Name/Relationship (Type, Print) 19b. Maliing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM MURRAY (BROTHER) PIONEER DRIVE SEVERN, MD. 21144 20b. Piace of Disposition (Neme of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1) Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) ANNAPOLIS MEM. GARDENS 4/1/98 ANNAPOLIS, MD. 21. Signatura of Funarai Service Licenses 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. eese Harry 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, auch as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Ceuse (Final disease or condition resulting in deeth) Konehour Examiner Physician/Medical Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in daath) Last Division of Vital Records, P.O. Box 68760, Part it. Other significant conditions contributing to death but not rasulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceusa of death? Completed 24a. Was an autopsy performed? certificata has 1 Yas 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitei: P Other: Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA this 28e. Date of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how tnjury occurred After 1 Neturei 2 Accident 5 Pending investigation n 24 hours after deeth.

Ne Funerel Director: Al after deeth. 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicida Piece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as steted.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and mannar stated. Medical 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signatura and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) D4195 3-26-98 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print).

Reset (Ca E70h M D 273B) mold on insula Farm Rd ca 31. Date flied (Month, Dey, Year) 32. Registrar's Signature State APR 01 wha Davidson

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Day Month Veal **Physician** APRIL MARY 10 1998 MAHONEY 4:00 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth Examiner 3010 GALLERY PLACE #21 WALDORF CHARLES If Undar 1 Yaar 5. Social Security Number if Undar 24 Hrs. 9. Birthpiece (State or Foreign Country) MARYLAND 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 YE 219-34-7905 60 Yrs Director Usuei Residenca of Decedent with the Merylenc 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 28a-f ahon 7 is marked other than "natural", or items 23a or 28a-f abov traumatic event, the Modical Examinor must be notified at 14 Yes 2□ No Director MARYLAND CHARLES WALDORF 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3010 GALLERY PLACE #21 20602 UNITED STATES Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc.
BLACK Pages 1 and 2 should be filed within 72 hours efter or and of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Item 1 Never Married 2 Married 1 Yes Z No Maryland 21215-0020 Specify ģ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highast grada complated) Elementery/Secondery (0-12) Coilege (1-4or 5+) OYSTER SHUCKER STEVEN NORRIS SEAFOOD 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) MARGARET ELIZABETH MIDDLETON GOOSEBERRY JOSEPH RICHARD GOOSEBERRY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3010 GALLERY PLACE #21 WALDORF, MARYLAND 20602 LILLIAN WASHINGTON/ DAUGHTER other t Saltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from Stata Injury or Depertment of Important: If HOLY GHOST CHURCH CEM. 4/15/98 ISSUE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) Mure of Funeral Service Licen 22. Name and Address of Fecility
THORNTON FUNERAL HOME, P.A. MADIA C. THORNTON M00583 JOHNSON 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final LUNG CANCER WITH METATASIS TO SPINE MA disaese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner buriel-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of): certificate be execu Box 68760 physician Physician/Medical ey Due to (or as e consequenca of): 80 USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o signed by the 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to 24a. Was en eutopsy Completed completion of cause of death? hes ZLI No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽ No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Death 28h. Time of 28c. Injury at Work? After t Certification: Naturei 2 Accident 5 Pending efter deeth. Director: Aff 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the To the To the 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D28352 APRIL 13, 1998 30. Nama and address of person who completed cause of death (item 23e) (Type, Print) KRISHAN MATHUR, M.D., P. O. BOX 2729, LA PLATA, MD

DHMH 16 Rev 6/95

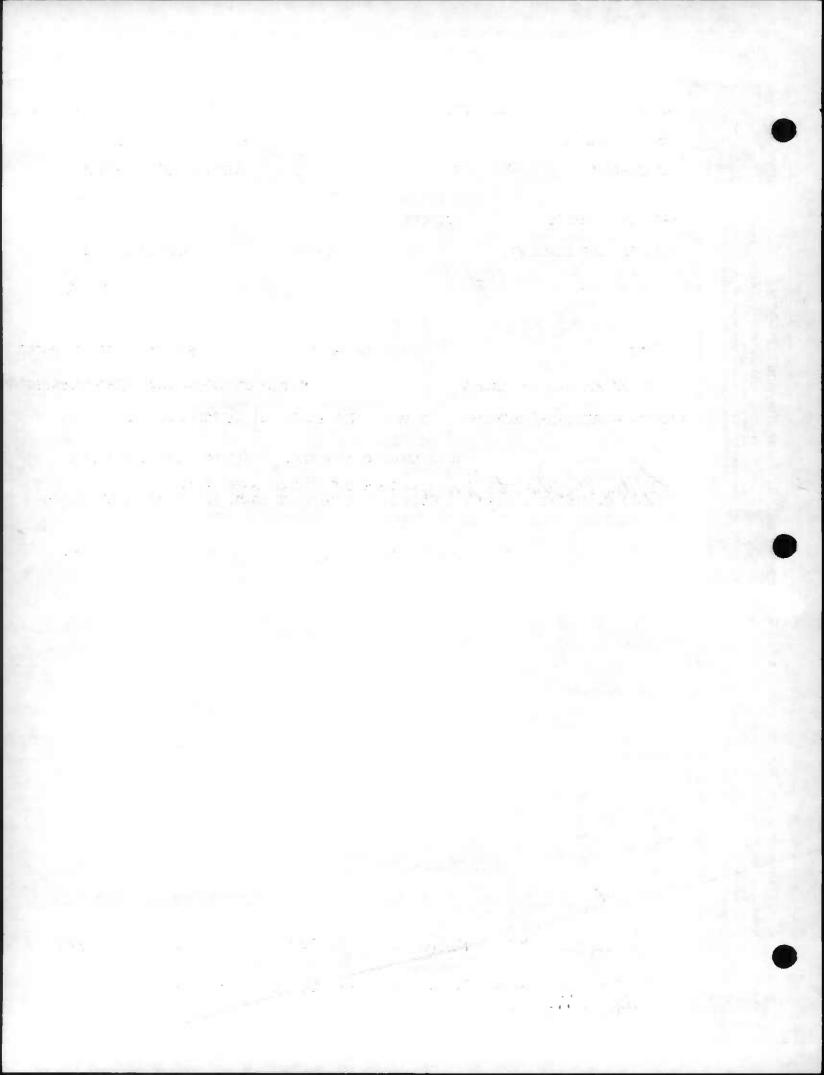
State

Registrar

31. Data filed (Month, Dey, Year)

4 1998 32. Registrar's Signature

This or Dudson Robert



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) APPIL USSI McMILLION 4b. City, Town, or Location of Deeth 4c County of Death

FUNCE GEOMGE County of Death 4a Facility Neme (If not institution, give street and number, 4819Z UNYON! AUSTRANA 8. Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Months Deys Hours M 2□ F JUNE 26, 72 1925 WEST VIRGINIA 234-34-4279 Usuel Residence of Decedent 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits MARYLAND PRINCE GEORGE'S 1 Yes 2 No **ACCOKEEK** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16400 CEDAR LAWN DRIVE 20601 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? ↑ Yes 2 No USA I Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Detes 1944-45 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 **TEACHER EDUCATION** 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) KENNA W. MCMILLION RACHEL JACKSON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MILDRED C. MCMILLION/WIFE 16400 CEDAR LAWN DRIVE, ACCOKEEK, MARYLAND 20601 20b. Piece of Disposition (Neme of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State TRINITY MEMORIAL GARDENS 4/14/1998 WALDORF, MARYLAND 5 Other (Specify) 4 Donation of Fune el Service Licensee THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX BROHAWN M00053 MARK G. 156, WALDORF, MARYLAND 20604-0156 23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or haert failura. List only ona causa on each lina. Immediate Ceusa (Finel 10 DAYS disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated avants resulting in death) Last Due to (or as e consequenca of) Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part 1. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy performed? 1 Yes 21 No 1 Yes 2 No 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

PY

Completed

7 is marked other than "natural", or items 23a or 28a-f shot traumstic event, the Mod Fail Examiner must be notified at

"natural", or

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Department of Health a Important: If item 27 Is any injury or other tra

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filed within 72 hours after

Pegas 1 and 2 should be

Maryland 21215-0020

Baltimore,

and attanding physician a for usa es the burial-80

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical nplately

tha signed by t peen ; has la 2 pega cartificate funaral director this 24 hours after deeth.

Funeral Director: After lilled in by

The law requires that the death cartificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760

25. Was casa referred to medical 1 Yes 2 No 27. Manner of Death

1 Naturel 5 Pending investigation 2 ☐ Accident 3 Sulcide 4 Homicide

29a. Cartifiar

6 Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledga, daeth occurred at the tima, data and place, end due to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and manner stated.

28d. Describe how injury occurred

(Check only one) 29b. Signatura end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

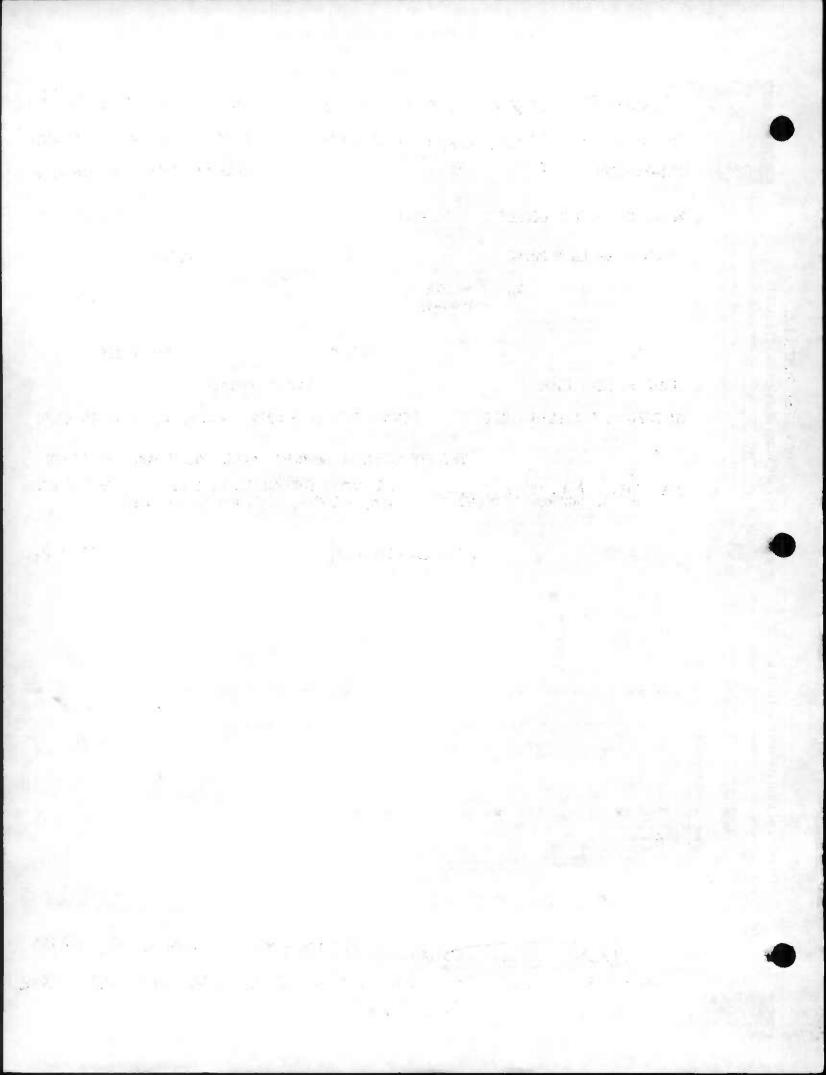
ddless of person who compiated cause of daath (Itam 23a) (Type, Print) LINE CENTER 700 OLD P. WISBESICH WD

31. Date filed (Month, Day, Year) 1998 32. Registrar's Signature

State Registrar

within 2

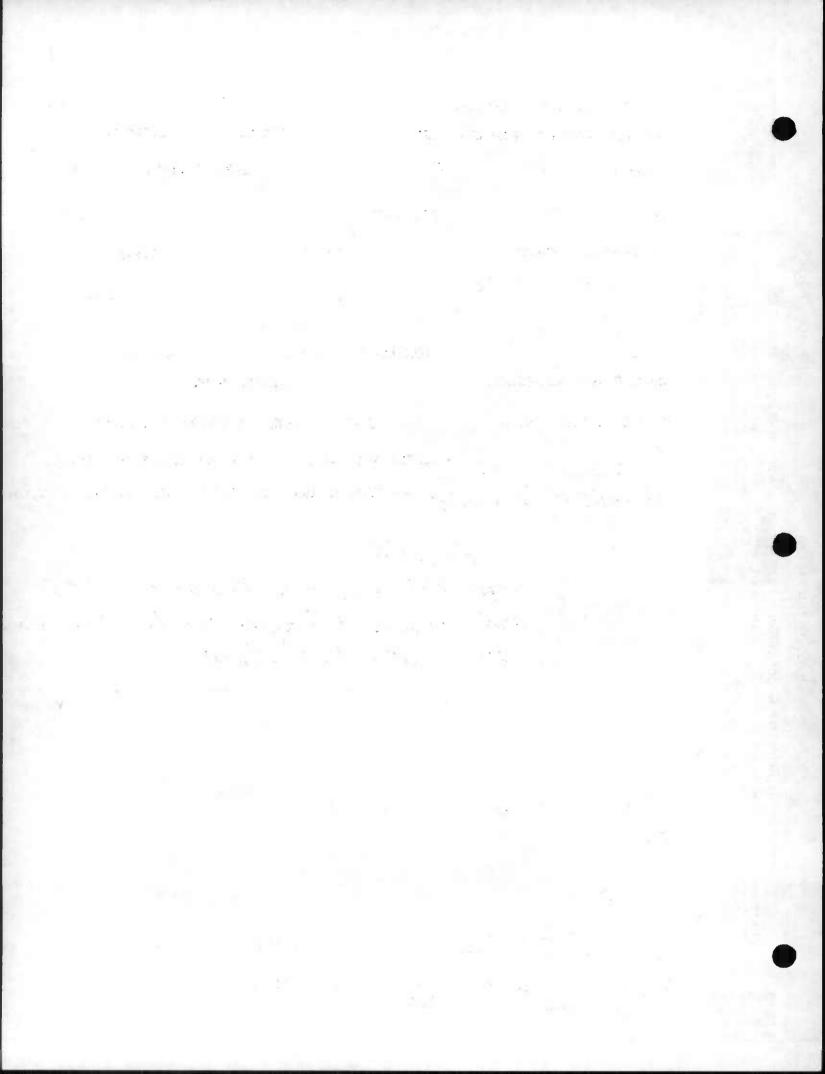
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State of Maryland / Department of Health and Mental Hygiene 9

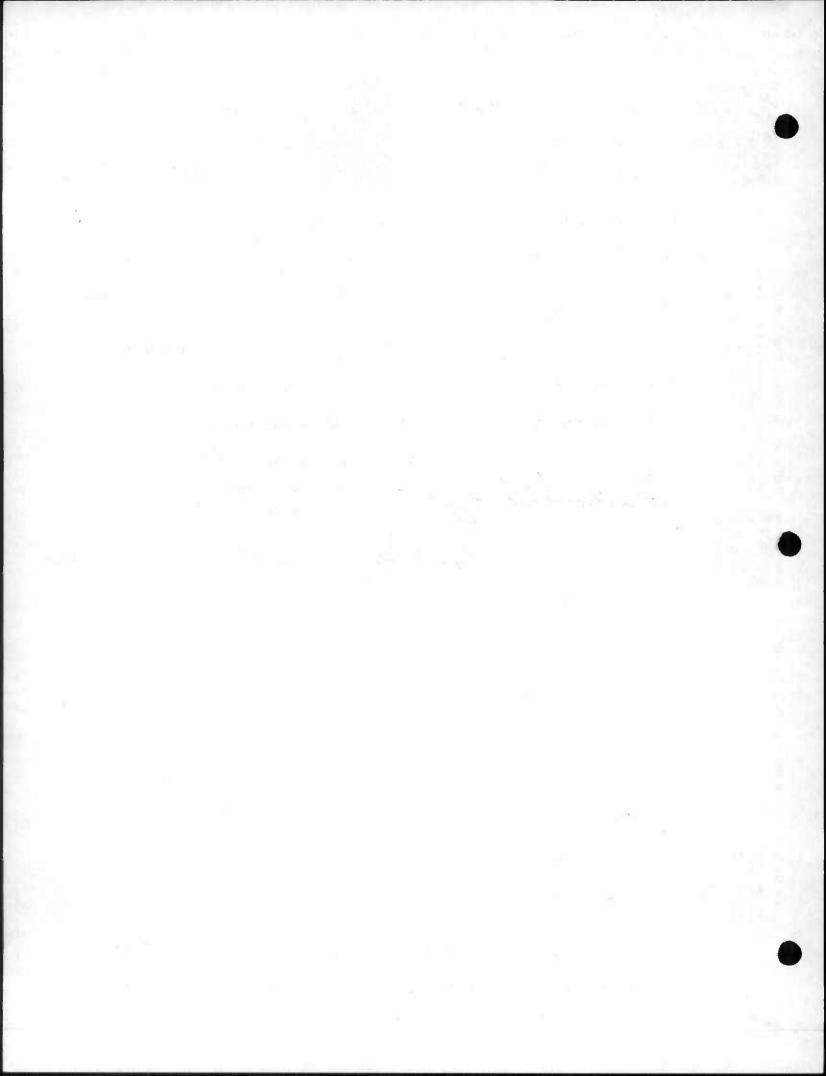
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799	020 urs effer alf, or ite	3 ☐ Widowed	rried 2{XMerried	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dec	ces? 2 X 1 No	J,S. 1:	3. Was Dece If Yes, spe 1 ☐ Yes				ecify Yes or No Ricen, etc.)	Blee	e - Americ ck, White, WHI	etc.
-	5-0 72 ho	/Sn	15. Decedent's E	ducetion		16e. De	cadant's Usu	el Occup	petion	ast of work	rina	16b. Kind of B	usiness/Ind	dustry
2	1 21215-002 ed within 72 hours ygiene. er than "natural", rt, the Madical Ev Completed by	Elemantary/Sec	condary (0-12)	College (1-	4or 5+)	life	a. DO NOT u	se retire	ed)	OSI OF WORK	ang.			
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7	iore, Maryland 2121 ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, ITEM TO Be Compi	TOCEDH	e (First, Middle, Last CALVIN MO								ED JONE:		10)	
	should Ind Meni		Name/Ralationship	Type, Print)		19b. Ma	ailing Addres	s (Stree	1		al Routa Numbi		Stete, Zip	Code)
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	Baltimore, semit. Pages 1 er Spartment of Heam mportant: if item: my Injury or other state.	20a. Method of Di	sposition		20b.	Plece of Dis	sposition (Ne	me of	ice)	1023	Dete	20c. Location		
	Page nent of int: If		Cremetion 3 ☐ Other (Speci		late		O MEM.				4/10/98	SALISBU	JRY.	MARYLAND
	Balti bemit. Departri Importa eny Inju	21. Signatur of	uneral Service Lice	nsee)	22. Neme er							21804
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	•	23a Part1. Enter shock, or he	the disease, or contact failure. List only	plications that ca one cause on ea	used the dea	ith. Do not	enter the mod	de of dy	ing, such	es cerdiac	or respiretory e	rrest,		Approximete Intarval Batwaan
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7	P.O. BO) at the deeth ce d by the attendi eteched for use	Pert tt. Other sign	ificant conditions	contributing to dee	eth but not re	sulting in the	e underlying	causa gi	iven in Pa	ırt I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
	P.O nat the dby the deteche										1 🗆	Yes 2□ No	3 Pro	bebly 4 Unknown
	cords, P.O. Boy vequires that the death ce been signed by the attend should be deteched for us. letted by Physician/	\									040 14/00		24h W	ere autoney findings
	of Vital Records, Physician: The law requires the this certificate has been signed infector, page 2 should be e. To Be Completed by										perfo	en autopsy rmed?	CO	ere eutopsy findings eileble prior to mpletion of ceuse
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	ith. Afte e fun	2 Accident	5 Panding investigation		, Dey Year)	Injur	У		ork?]Yes 2	□No				
	Division or Attending after death. Director: After d in by the fune ertification	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	289. Place	of Injury - At I	home, farm,	straet, fector	y, office			28f. Location (City or Tot		ber or Rure	el Route Number,
	Division Cale or Attending P is after death. The process of the funer ed in by the funer Certification:	4 Homicide		building	g, etc. (Spec	ny)					Only or To	m, ololo,		
	Division of Vital Re To the Hospital or Attending Physician: The live Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		Certifying Pi 2 Medical Exa	nyelclan: To the bas miner: On the bas end menne	sis of exemin	owledge, de etion and/or	eeth occurred r investigation	et the t	ime, dete opinion, d	end place, laeth occur	and due to the red et the tima,	ceuse(s) end m data end place,	enner as s and due to	tated. the cause(s)
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-		19	11	ach	2			L) 19	280	7	4-	7-95	8
	\bigcirc	30. Neme end and	dress of person who	completed causa	of daath (Ita	m 23a) (Tyr	pe, Print)							
	8	Charle	ZG	rab m	0	Sali	sbury	M	02	1801				
	State	31. Date filed (Mo	enth, Day, Year) PR () 8 1998	P. Ra	distrer's Sign	Wardell .	6			,				
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene | 2 8 0 8

						Certificate o	f Death		Reg. No.	0 1	2000
	Dharaia		1. Decedent's Name (First, Middle, La	ist)				2. Dete of De Month	eth	Voor	3. Time of Death
	Physic /Medi		EFFIE	MAR	ΙE	MERWIN			8, 19	98 Yeer	8:05 AM
	Exami		4a. Fecility Neme (If not institution, given	re street and number)			4b. City, Town, or L	ocation of Death	4c. Co	unty of Death	1
1			1116 Camden Ave	е			Salisbu	ıry	Wi	comico	
	Funeral		Sociel Security Number 6. 9		e (In yrs. las	Months Day		8. Dete of Bir (Month, Da	th v. Year)	9. Birth	hplece (Stete or Foreign
	Director		390-05-6150	1□M 2⊠F	84	Yrs.		5/21/	13		sconsin
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c City T	own or Location					404 toolds Ob. 11-b.
	eho eho	5			0						10d. Inside City Limits 1 1 Yes 2 □ No
	the N	Director	Wisconsin LaCr	osse		LaCrosse					
	with or					10f. Zip Code		10g. Citizan of Whet Counfry?			
	s 23	Funeral	1422 Redfield St	Y	Tues in 11 C		601	14 24 24		USA	1
	Herri	5	11. Merifal Sfatus 1 ☐ Never Married 2 ☐ Married	12. Wes Decedent B Armed Forcas? 1 Yes 2 10 N		If Yas, specify Co	f Hispanic Origin? (Sp uben, Mexican, Puerto	Rican, etc.)	- 14.	Race - Ameri Bleck, Whita	
Maryland 21215-0020	72 hours efter deeth with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notified at	by F	3 ☐Widowed 4 ☐ Divorced	If Yes, Give	•0	1 □ Yes 2/2 N	lo Specify:		Spe	ecity: Wh	hite
9	d 2 should be filed within 72 hours th and Mental Hygiene. 7 is marked other than "natural", traumatic event, tra Medical Exa	8	15. Decedent's E		1	6e. Decedent's Usual Occ	cupation		16b Kind o	of Business/li	ndustov
215	nin 7	Completed	(Specify only highest gr	ade completed)		(Give kind of work dor life. DO NOT use reti	ne during most of work ired)	dng			
21	filed within Hygiene. Ither than "	E	Elementery/Secondery (0-12)	College (1-4or 5	+)	Homemaker			Domes	tic	
b	office of the of	Bec	17. Fethar's Nama (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sur	neme)	
/lai	2 should be and Mentat is marked o	ToE	William Haggert	У			Daisey	Hutson			
an	sho and A		19e. Informant's Neme/Reletionship (Type, Print)		19b. Mailing Address (Stre	eet end Number or Rui	rai Route Numbe	er, City or To	wn, State, Zi	ip Code)
	CHUF		William Merwin/S	on		1116 Camd	en Ave., S	alisbur	y, MD	21801	
Baltimore,			20a. Method of Disposition		20b. Plec	e of Disposition (Neme of etery, cremetory or other of	place)	Dete / O C		on - City or T	Town, Stete
E	C3 D		1 Magazial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		Catho	lic Cemetery of	La Crosse	4/11/98	LaCro	sse, I	WI
alti	pemit. Pa Depertmen Important: any Injury once.		21. Signature of Funeral Service Lice	\$ 00		22. Neme end Add					
m	Dep Impo		1601/4	e Uhr =			y Funeral				
	-	0	2.1. Part1. Enter the disaesa, or com hock, or heert feilure. List only	plications thef ceused	the death.	501 Snot Do not enter the moda of d	W Hill Rd. lying, such as cardiac	 Salis or respiretory en 	bury,	MD 218	Approximeta
d	Physician		nock, or neer tellure. List only	one ceuse on eech iin						1	Intervel Between Onset end Death
į.	/Medical		Immediata Ceuse (Finel diseese or condition	Zan A	of 1/1	myclana	/ hatist	F. 21.			12-
	Examiner		resulting in deeth)			s e consequence of):	1 reas	me)			6 mor
_	n =	ner			(1	
	The law requires that the death certificate be executed ste has been signed by the ettending physician and pege 2 should be detached for use es the bunet-transit	Examiner	Sequentially list conditions.	b	Due to (or es	s e consequence of):					
ó	e exe ian a uniel-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							1	
68760,	ete b hysic the b	Medical	thet initieted events rasulting in death) Lest	С.	Dua fo (or as	a consequence of):				1	
9 >	ing pl	Mec		a'						-	
Box	eeth ce ettendia for use	an/		d							
	the e	Physician/	Pert II. Other significant conditions of	ontributing to death bu	it not rasultir	g in tha underlying cause	given in Pert I.	23b. Dld 1	lobacco use	contribute	to the cause of deeth?
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orc	v require been si should	Completed							en autopsy med?	a	Vere eutopsy findings vailable prior to
e C	has be	ple									complation of cause of deeth?
<u> </u>	The liste has pege	Son						101	Yes 2 N	0 1	☐ Yes 2☐ No
of Vital Records,	certificate	Be (25. Wes case referred to medical examiner?				26. Place of Deal	th (Check only o	ne)		
> 5	0 0	ပ္	1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER	/Outpetlent 3□ DOA	Other: 4 Nursing Ho	me 5 Resid	dence 8 🗆	Other (Speci	eify)
	ofing Ph h. After th funeral	iio	27. Manner of Deeth 1 SNaturel 5 ☐ Pending	28e. Dete of Injur (Month, Dey	Year) 28	b. Time of 28c. In Injury	jury et /ork?	28d. Describe I	now Injury oc	curred	
Slo	Attending or death. actor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not b			M 1	☐ Yes 2 ☐ No				
Division	or Attendents of the Control of the	Certification:	4 Homicide determined	28e. Plece of Inju building, etc		, ferm, street, fectory, offic	a	28f. Location (S City or Tov	Street end Ni vn, Stete)	imber or Rui	ral Route Number,
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	Hospital 24 hours Funeral stely filled	edical	(Check only 2 Medical Exar	niner: On the basis of	examinetion	dge, daeth occurred at the end/or investigation, in my	time, dete end plece, y opinion, deefh occur	end due to the red of the time,	ceuse(s) end dafe end pla	menner es : ce, end due :	ststed. fo the ceuse(s)
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	IJ.		Dr. Charles Steg 31. Dete filed (Month, Day, Year)			Vernon Rd.,	Princess 1	Anne, MI	2185	3_410	0-651-0350
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State of Maryland / Department of Health and Mental Hygiene

2809 Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) o'Dono van **Physician** Jeremian 0214 march 30,1998 /Medical 4e Fecility Nema (If not Institution, giva straat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS Haltimore HOSPI If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1∑M 2□ F Hours Yrs 579-12-1526 Director June 22, 1920 Washington, D.C. Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as once. 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 853 Inverrary Court 21401 U.S.A. Funerai 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 1 □ Navar Married 2 Namled Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Insurance Insurance Agent 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fathar's Neme (First, Middla, Last) Jeremiah Joseph O'Donovan Julia Murphy 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 853 Inverrary Court, Annapolis, Md. 21401

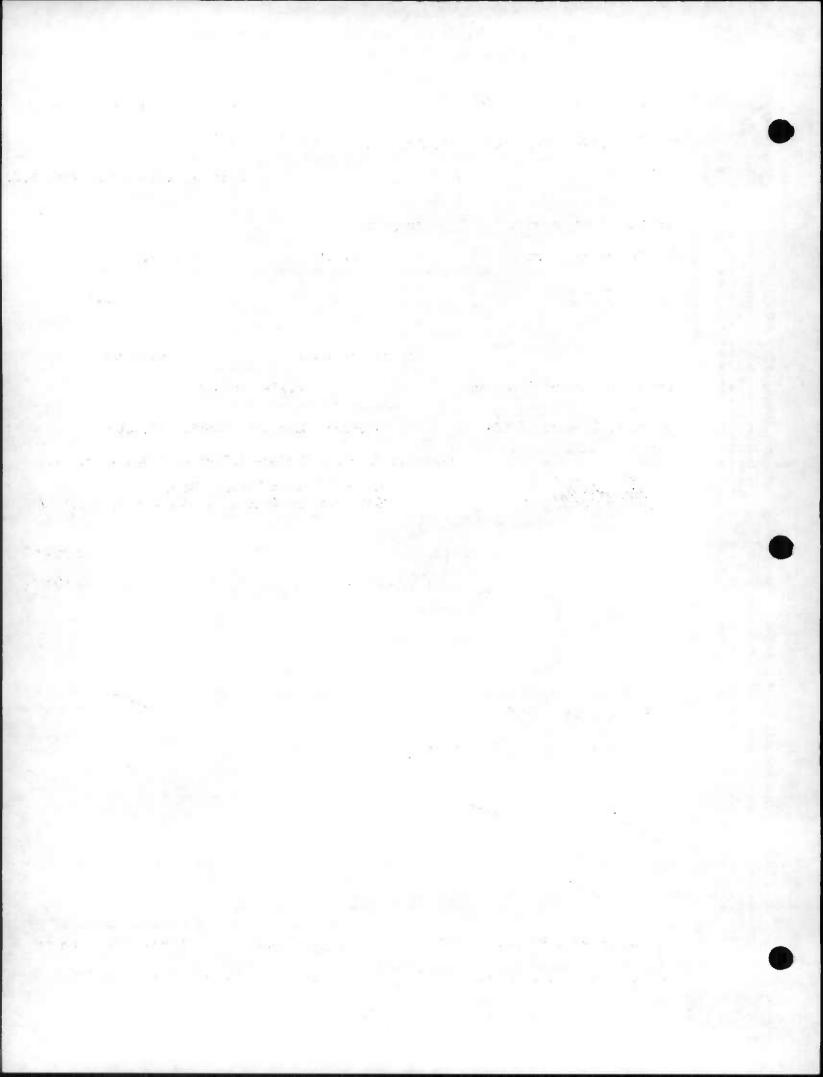
Loca of Disposition (Nama of the Court)

Dete 20c. Location - City or Town, Stata Lenore A. O'Donovan/Wife 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Mathod of Disposition 1 Deurial 2 Cramation 3 Ramoval from Stata Lakemont Memorial Gardens 4/2/98 Davidsonville, Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md.21037 23a. Part1. Enter the disease, or complications that ceusad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Sepsis disease or condition resulting in deeth) Examiner Due to (or es e consequence of): 6 days infection Physician/Medical Examiner central line physicien end the buriel-transit lew requires that the death certificate be executed Dua to (or as a consaquanca of): Sequantially list conditions, if eny, laading to immadiata ceusa. Enter Underlying Cause (Disaase or injury Division of Vital Records, P.O. Box 68760 thet initieted evants rasulting in daeth) Last Due to (or as e consequance of): ettending phy signed by the e Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ulcerative colitis þ 24b. Wara autopsy findings evallabla prior to complation of cause of deeth? 24e. Was an autopsy Completed insufficiencu adrenal is certificate has director, page 2 1 Yas 2 THO 1 Yas 2 No or Attending Physician: 25. Wes cesa referred to medical axaminar? Be 26. Place of Daath (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No To the Hospital or Attandit within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. invastigation 2 ☐ Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 29a. Certifiar Cartifytng Phyaictan: To tha bast of my knowledga, death occurred at tha tima, dete and plece, and dua to tha cause(s) end manner as statad. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. Licansa number march 30,1998 K. nakahw) a RES-000 30. Name end eddress of person who complated cause of deeth (Item 23a) (Type, Print) street Baltimore, maryland 21287 Eric K. Makakura 600 North wolfe 31. Dete filed (Marth Pay, 0°1) 1998 32. pegistrer's Signatura

Juna Davidson-Randelle State Registrar

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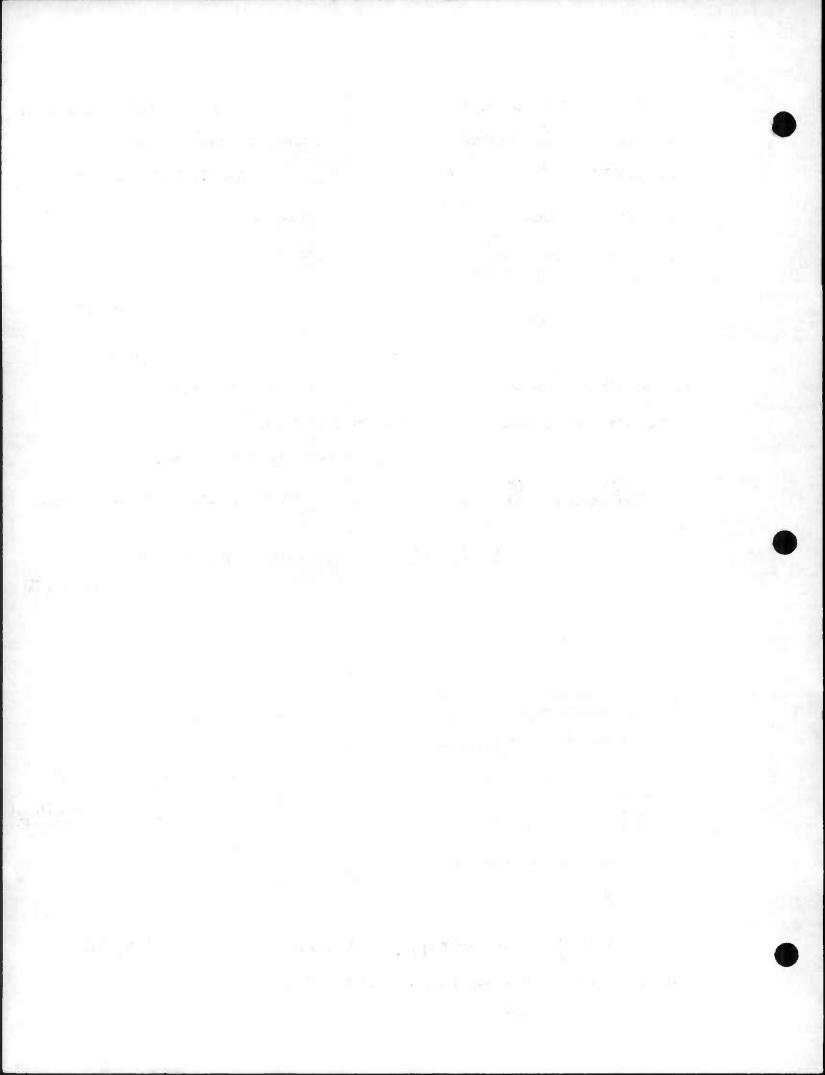


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time f Lee th Month **Physiclan** FRANK OWINGS **OSBOURN** 1998 2:55 a.m. April 9 /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year if Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₽M 2□F Yrs 214 28 4517 Director 70 Jan 11, 1928 Maryland Usual Rasidence of Dacedant with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at Maryland Calvert Director Huntingtown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1755 Lower Marlboro Road 20639 USA permit. Peges 1 and 2 should be filed within 72 hours after deeth N Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any Injury or other traumatic event, pr. Med 51 Earther man 12. Wes Decedant Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Nevar Marriad 27 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: Saltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) farmer agriculture 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) William Richard Osbourn Mary Viola Wayson 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mrs. Elizabeth A. Osbourn same as # 10 above 20b. Place of Disposition (Nama of cematary, cremetory or othar place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 4-11-98 4 ☐ Donation 5 ☐ Other (Specify) Lower Marlboro Cemetery Owings, MD 21. Signature of Funarei Sarvice Licensee 22. Name and Addrass of Facility len 5 Rausch Funeral Home, P.A., Owings, MD 20736 U 23a. Part1. Enter the disease, or complicated to that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth **Physician** /Medical tmmediete Cause (Final Metastatic Carcinoma Rt Lung. disaase or condition resulting in daath) Examiner Dua to (or es e consequance of) Examiner physician and the burief-transit Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequance of): aftending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Ateletisis 1 Yss 2 No 3 Probably 4 Unknown þ aspiration been si 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy has certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was casa raferred to medical Be 26. Place of Deeth (Check only ona) axaminar? Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Transition ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) come wint 27. Manpar of Death Certification: 26b. Tima of 28c. Injury et Work? 26d. Dascribe how injury occurred 1 Naturel 2 Accidant 5 Pending 1 Yas 2 No investigation 6 Could not be datarmined 3 Suicide 28e. Plece of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicida 29a. Cartifian 1 certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 98 turn' 10man 30. Neme and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) Dr. Zahir Yousaf, M.D., Huntingtown, Maryland 10 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 1998 Julis Davidson Randall Registrar

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	Physic		ELWOOD				PURI	NELL.	APRIL.	09	1998	4:50 AM	
Š.	/Medi Exami		4e. Fecility Neme (If not institution, giv	re street and numbe	r)		- 014	4b. City, Town, or					
1			Berlin Nursing &	Rehab Ce	nter			Berlin	1	W	orces	ter	
3	Funeral Director	Г	5. Sociel Security Number 6. S 214-18-4264	Sex 7. A	Age (In yrs. I	last birthday) Yrs.	if Under 1 Ye Months De		8. Date of Bir (Month, Da Sept 1	8. Date of Birth (Month, Day, Yeer) 9. Birthplece (Country) Sept 18,1911			
	and w		Usuel Residence of Decedent 10a. State 10b. County		100 City	y, Town or Lo	notion						
	e Maryla Ba-f sho	ctor	MD Worces	ter	Toc. Oil	Berli					1	0d. Inside City Limits 1X☐ Yes 2☐ No	
	or 2	Dire	10e. Street end Number				10f. Zip Cod	le	10g. Citizen			itry?	
	ath v 23a	rai	10530 Flower St.			*		21811		U.			
020	within 72 hours effer death with the Maryland jiene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Married 4 Divorced	12. Wes Deceden Armed Forces 1 Tyes 2X If Yes, Give Yeer or Dates	;?] No		Vas Decedent of Yes, specify C	of Hispanlc Origin? (Scuben, Mexicen, Puerl No <i>Specify:</i>	pecify Yes or No to Ricen, etc.)	Specif	en Indien, etc. ack		
5-0	72 ho	ted	15. Decedent's E (Specify only highest gre	ducation	T	16a. Decedent's Usual Occupetion			deine	16b. Kind of B	usiness/Inc	dustry	
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yla	2 should be f end Mental I is marked of aumatic eve	2	Lee Purnell					Hennie					
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e, l	f Health fem 27		Oliver Gordon Pu 20e. Method of Disposition	rnell/son			J FLOWE sition (Name of netory or other)	r St., Ber	Date Date		O!b		
Baltimore,	nt of nt of nt of or		1 Suriel 2 ☐ Cremetion 3 ☐			20c. Location							
Ħ	it. P.		4 ☐ Donation 5 ☐ Other (Specifical Signature of Fundral Service Licer	1 1	St.		Cemete		1/13/98	Berli	n, MD		
Ba	permit. Pages 1 en Department of Heali Important: If item 2 any injury or other ance.		21. Signature of Furnital Service Licer	2			Lewis N	dress of Fecility . Watson E st Rd., Sa			301		
			234. Part 1 Enter the disease, or com shock, or heart failure. List only	plications thet cause one ceuse on each	ed the death line.	. Do not ente	er the mode of	dying, such es cerdia	or respiretory e	rrest,		Approximete Intervel Between	
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	outed Id ansit	amir.	Sequentially list conditions	b		es e consequ		71.00	777		7.	9,	
8760,	death certificate be executed e ettending physicien end of for use as the buriel-transit	licai Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	c	360.	es e consequ	200111						
Box 6	eath certifica ettending ph I for use as th	Physician/Me	L	d									
		sici	Pert II. Other eignificant conditions of	ontributing to death	but not resu	Ilting in the un	derlying cause	given in Pert I.	23b. Did	tobecco use co	ntribute to	the cause of deeth?	
s, P.O.	requires thet the de seen signed by the hould be deteched	by Phy	Jemi 11	15.					10	Yes 2□No	3 Prob	Dably 4 Unknow	
Records,	- U W	Completed							24e. Wes	en eutopsy ormed?	eve	ere eutopsy findings eileble prior to mpletion of cause deeth?	
Ä	9 E 5	E O							10,	Yes 2K No	10	Yes 2 No	
Vital	sician: The certificate irector, pag	Bec	25. Wes case referred to medical exeminer?					26. Plece of Dea	ath (Check only o	one)			
of V	Physician: r this certific ral director,	2	1 ☐ Yes 2 🛣 No			ER/Outpetient	3□ DOA	Other: A Nursing H	ome 5 Resid	dence 6 □Oth	er (Specify	<i>(</i>)	
n c	ng Pl	Ë	27. Manner of Deeth 1 Neturel 5 □ Pending	28a. Dete of Inj (Month, D	ury e <i>y Year)</i>	28b. Time of Injury	28c. ir			how injury occur			
Sio	Attending ir death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					☐ Yes 2☐ No					
Division	al or At s efter of il Direct ed in by	Certification:	4 Homicide determined	28e. Piece of in	ijury - At hor tc. (Specify,	me, farm, stre	et, factory, offic	08	28f. Location (S City or Tov	Street end Numl vn, State)	er or Rure	l Route Number,	
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edicai	29e. Certifier 1 Certifying Ph. (Check only one)	yelclen: To the best ilner: On the besis end manner s	of examineti	vledge, deeth ion end/or Inv	occurred et the estigation, in m	e time, date end place y opinion, deeth occu	, end due to the rred et the time,	ceuse(s) and modete end place,	enner es st end due to	eted. the ceuse(s)	
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)								. , ,					

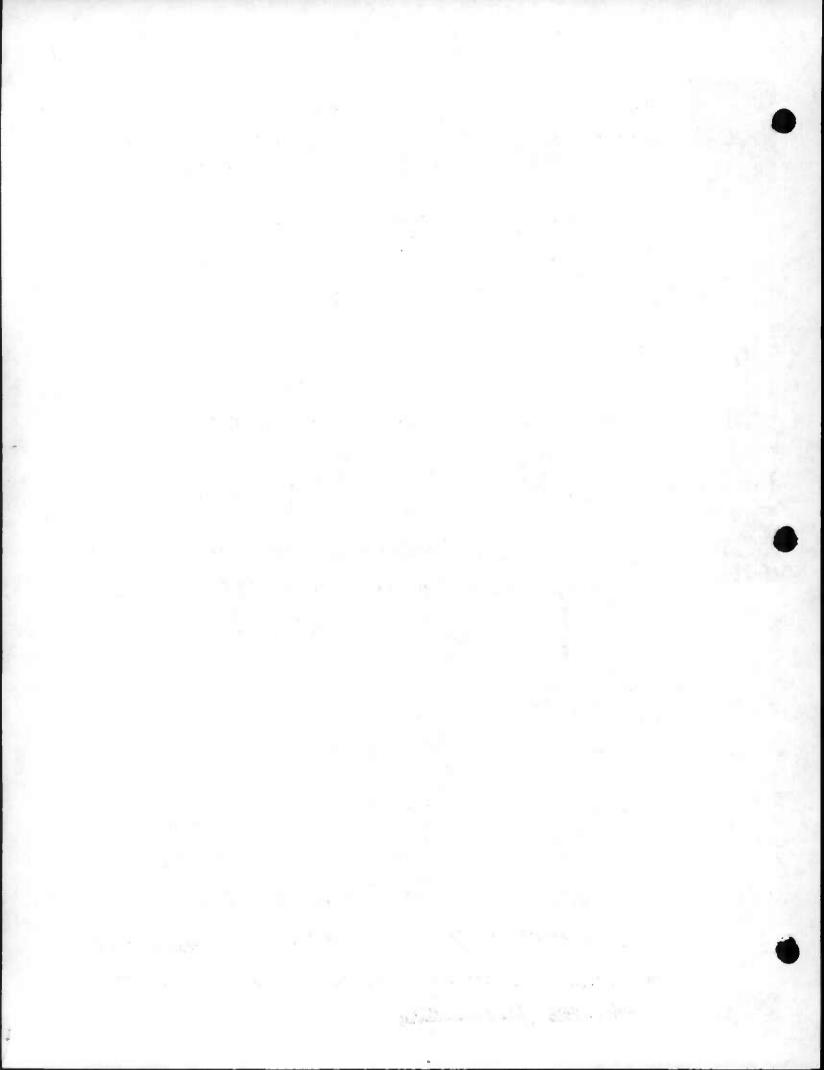
State Registrar

31. Date filed (Month, Dey, Year) APR 13 1998

FEDERICO G. ARTHES MD

32. Registrer's Signeture Talia Davidson Randall

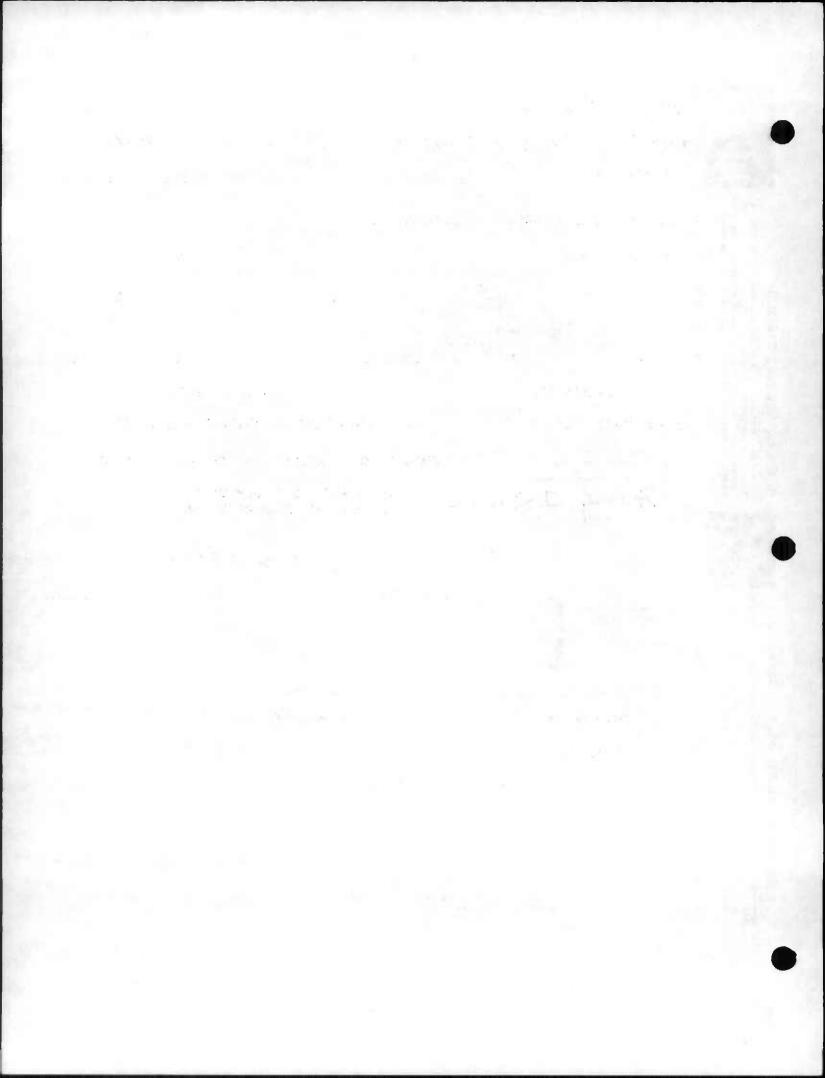
1622A OCEAN PINES BERLIN MD 21811 410-641-4400



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Tima of Deeth 1. Decedent's Name (First, Middla, Last) Month **Physician** 11:00 Am /Medical 4b. City, Town, or Location of Death 4c. County of Death (If not institution, give street end number) Examiner HWOOD NURSING 5. Sociel Sacurity Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2√F Months Deys 216-35-3375 Director MAY 3 1921 MARYLAND 76 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified. 10a State 10b. County 10c. City. Town or Location 10d. Insida Cltv Limits Yes 2 No ANNE ARUNDEL CROWNSVILLE Directo MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2105 EDWIN LANE 21032 US Funeral Wes Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indien, 12. Was Dacedant Evar in U,S. Armed Forces? 11. Marital Stetus Black, Whita, atc 1 Never Married 2 Married 1 ☐ Yes 2X No 1 ☐ Yes ŽXNo Specity: Specify: BLACK à 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC OUT OF THE HOME 6th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Nama (First, Middle, Last) NELSON BELL CECILIA A. BROOKS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) JAMES SMITH (SON) 2105 EDWIN LANE CROWNSVILLE, MD. 21032 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Removel from State ANNAPOLIS MEM. GARDENS 4/3/98 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fecility 21. Signature of Funeral Sarvice Licensee WM. REESE & SONS MORTUARY, P.A. arr 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. 200 Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) araro Norpir ata Examiner Examiner 5 drok physiclen end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es a consequance of) esn nse signed by the e Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Ware eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy Completed is certificate hes director, pege 2 25. Wes case referred to medical examiner? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 1 Neturel 5 Pending s efter dea. 1 Yes 2 No Investigetion 2 Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

2 Medical Exeminer: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. 29a. Certifier ecical (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licansa number 25000 MB 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) # p G/on Blunk 14 p. 2106/ 45/4 10-0 APR 03 32. Registrar's Signature State 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene O

Physician
/Medical
Examiner

Funeral Director

with the Marylend worls .

Pages 1 end 2 should be filed within 72 hours efter death with the Maryles neat of Health and Maralla Hyglench and the farms 23a or 28a-f shown if femr 27 is marked of the than "natural", or items 23a or 28a-f shown into or other traumatic event, the Wedless Examine must be notified any permit. Page Department of Important: If any injury or page.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours eight death.

To the Funerel Director: After this certificate has been signed by the eitending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 1998 Month March 28, William George Stevens, III 7:50 A.M. 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Union Memorial Hospital **Baltimore** 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) XXM 2□ F Deys 196-24-6035 67 Yrs. Pennsylvania 1930 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits WYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2500 West Belvedere Avenue 21215 USA Completed by Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 D Vo If Yes, Give Yaar or Dates: 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 1X Never Merriad 2 ☐ Married 1 ☐ Yes 2XXNo Specify: White 3 □ Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th N/A Disabled 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be William George Stevens, Jr. Eva M. Kinsey 2 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 316 Mill Swamp Rd. Edgewater, Maryland 21037 James R. Stevens/ Brother 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete XXBurlel 2 ☐ Cremation 3 ☐ Removei from Stata Woodlawn Mem'l. Park 4-1-98 Easton, Marvland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of 22. Name end Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edg.
23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, Md. 21037 Approximete Intervel Between Onset and Death Immediate Ceusa (Final Diabetes Mellitus 5 yrs. disaesa or condition resulting In deeth) Due to (or es e consequence of): Examiner 5 yrs. Hypertension Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disaase or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 3 yrs. Neuroarthroputy Physician/Medical Due to (or es e consequence of): Pert ii. Other significent conditions contributing to deeth but not resulting in the underlying ceusa givan in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Depression þ Be Completed 24b. Were eutopsy lindings evailable prior to 24e. Wes en eutopsy performed? completion of causa of deeth? 2 🗆 No 1 ☐ Yes 2€ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminar? 1 Yas 2 YNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1√2 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending invastigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

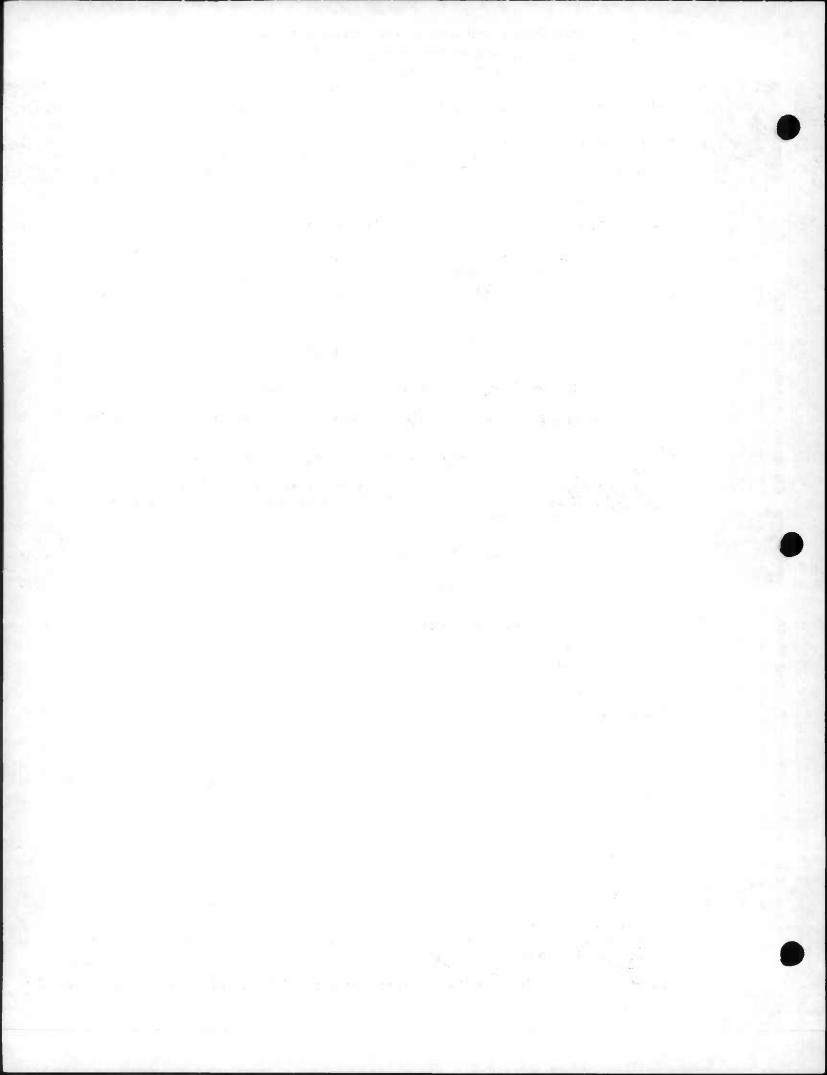
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner statad. Medical 29b. Signature 29c. License number 29d. Dete signed (Month, Dey, Year) March 28, 1998 Resident Com ns of person who completed cause of seath (him 23e) (Type, Print) 30. Name and ad Union Memorial Hospital 201 E. University Pkwy. Balto., Md. Sean D. Toomey, M.D.

State Registrar

31. Dete flied (Month, Day, Year) APR 01 1998

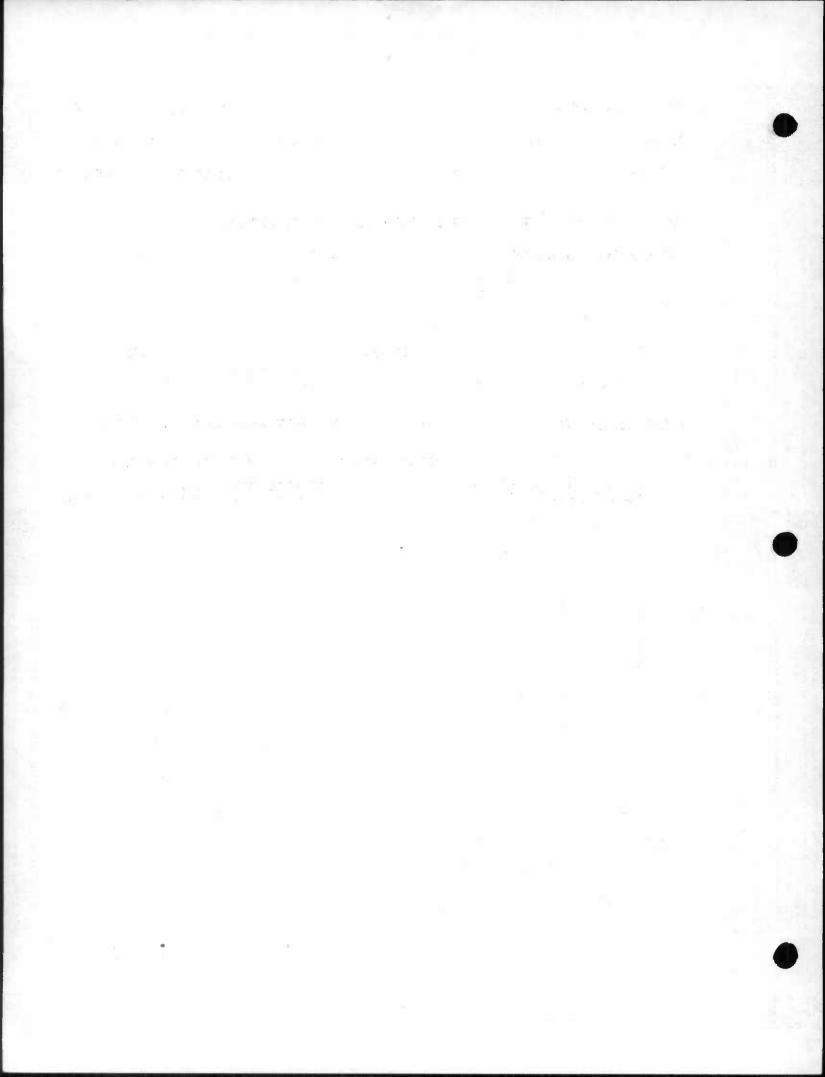
32 Registrer's Signeture

ilia Davidson-Randelle



				State	of Marylar		artment of <i>rtificate o</i>		l Mental Hyg	giene 3	12	2814
	Physici	an	1. Decedent's Name (First, Middle,	,					2. Deta of Dea Month		Yaar	3. Time of Death
	/Medi		MARIAE. SAME						4	14	98	12:01a.m.
	Examir	ner	4a. Fecility Neme (If not institution, 15110 POPLAR HII		umber)			ACCOKEE	or Location of Death			DOE
Н	- Francisco			Sex	7. Aga (In yrs.	lest birthdev)	if Under 1 Yaa			PRINC		IKGE ieca (State or Foreign
П	Funeral Director		285-30-5282	1□M 2∰F	76	Yrs.	Months Day	s Hours M	n. 8. Date of Birth (Month, De)	v. Year) -21	Coun	NGARY
	D		Usuei Residenca of Decedent									
	show	-	10a. State 10b. County			ty, Town or Lo					10	0d. Inside City Limits 1 ☐ Yas 2 ĀNo
	he M	Director	MD PRINCE	GEORGE	1511	lo POPL		ROAD, A				
	with	Ö	10e. Streef and Number 15110 POPLAR HIL	I ROAD			10f. Zip Code	507		10g. Citizen of \		try?
	be filed within 72 hours after death with the Maryland nei Hygiene. d other than "naturat", or thems 23s or 28s-f show event, the Medical Examiner must be notified at	Funeral	11. Meritai Stetus		cedant Ever in U	I.S. 13 V			(Specify Yas or No-		SA e - America	an Indian
0	r her	Fun	1 Nevar Married 2 Married	Armed F	orces? 200 No				(Specify Yas or No- erto Rican, etc.)	Bied	ck, Whifa,	
02	alf, o	by	3 Widowed 4 □ Divorced	If Yes, G Yaer or I	ive Detes:	1	I□Yes 2 No	Specify:		Specify	WHIT	E
5-0	72 h	Completed	15. Decedent's (Specify only highast)	Education grade completed)	(Give	lent's Usual Occi	e during most of w	orkina	16b. Kind of B	usiness/Ind	lustry
12	within ane. than	mpi	Elementery/Secondery (0-12)		(1-4or 5+)	life. E	DO NOT use retir LPTOR	ed)		PRIV	A ጥ ፔ	
d 2	Hygir in,	S	17. Fether's Neme (First, Middle, La	ist)		500	DI TOK	16. Mother's N	eme (First, Middle,			
lan	and Mentei and Mentei amerked of rurnetic eve	To Be	EDUARD		BAUER					ERGER		
ary	2 should be and Menter is marked reumatic e	-	19e. Informent's Neme/Reletionship	(Type, Print)		19b. Meilin	ng Address (Street	et end Number or	Rural Route Numbe	r, City or Town,	State, Zip	Code)
Σ	Heelth a tem 27 is other trac		EDWARD LUEDTKE/S	ON		404 V	ISTA WAY	Y, FORT V	VASHINGTO	N, MD	20744	
ore	ges 1 end 2 should it of Heelth and Men if item 27 is marks or other traumatic		20e. Method of Disposition 1 ☐ Burlei 2 ☐ Cramation 3	□Removel from		Plece of Dispos cemetery, cren	sition (Neme of natory or other pi	ace)	Dete	20c. Location -	City or To	wn, Stete
<u>E</u>	ment tant: I		4 □ Donetion 5 □ Other (Spe		Hill	TT CRE	MATORY		4-14-98	WALDOR	F, MD	
Baltimore, Maryland 21215-0020	permit. Peges 1 en Department of Heel Important: If item 2 any injury or other ance.		21. Signature of Funaral Service Lie	ansee)		22 T	HORNTON	FUNERAL	HOME, P.	Α.		
_	00500		LEON THORNTO			3	439 LIV	INGSTON I	ROAD, IND	IAN HEAD	D, MD	20640
	Physician /Medicai Examiner	er	shock, or heert feilura. List or immediata Cause (Finel diseese or condition resulting in death)		et while	e Re	uenca of):	ance				Intarval Batween Onset end Deeth
ox 68760,	thet the death certificete be executed ed by the attending physician and detached for use as the burlet-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	c	·	or as e consequ						
Box	d for t	icia	Part II. Other algnificant conditions	contributing to a	leeth but not ree	ulting in the us	darbing cauca c	iven in Part I	23h Dide	ohacco usa co	ntribute to	the cause of death?
0	t the by the tache	hys	tata. Outer agrinoant condition	Contributing to c	Jaoth Dut Hot las	iditiilg iii trie di	idanying cadsa g	jivaii jii Faiti.		ree 2□No	3 □ Prob	./-
S,	gned be de	by F							-			
Division of Vital Records, P.O.	The lew requires that the death certific tie has been signed by the attending page 2 should be detached for use as	Completed							24e. Wes e perfor		ava	ora eutopsy findings allable prior fo mpletion of cause death?
E									1 🗆 Y	es 2 No	10	Yas 2□ No
Ë	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	Hospitel:			10	ther	eeth (Check only or			
ō	Phys r this aral di	1: To	1 ☐ Yes 2 No 27. Menner of Deeth	1	·	ER/Outpatien	1 30 DOV	4 LI NUISING	Home 5 Resid)
o	offing th.: Afte tune	ation	1 Naturei 5 Pending 2 Accident investigat		of Injury oth, Dey Year)	injury	W	ork? ⊒Yes 2 ⊒No				
N/S	or Attending after deeth. Director: After I in by the lune	Certification:	3 ☐ Suicide 6 ☐ Could not determine	208. Plec	a of injury - At he	ome, ferm, stre	eet, fectory, office	9	28f. Location (S City or Tow		er or Rura	l Route Number,
ō	tai or rs aft al Dir led in	Cer		John	ang, arc. (opecn	,,			Only or You	n, otatoj		
	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	Medical	29e. Certifier 1 ★ Certifying I (Check only one)	aminer: On the b	e best of my kno basis of examine nner stated.	wledge, deeth tion end/or inv	occurred et the restigetion, in my	time, dete end pie opinion, deeth oc	ce, end due to the c curred et the time, c	ceuse(s) end me dete end plece,	and dua fo	eted. the cause(s)
	To t	Σ	29b. Signeture and title of cartifier					nse number		29d. Data signe		
			1-76	1				0453	5	4-	-16	-98
			30. Neme end eddress of person wh					- TT 1 ·			l	
	-01		Sidarous, MD 31. Dete filed (Month, Dey, Year)		Livings Registrar's Signa		ad For	c washing	gton, Mar	yıand		
	Sta Registr	-	APR 1 4		eli Dave	Lear Rand	late					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 8 | 28 | 5

								Cei	rtificate	of	Death		F	Reg. No.		0 1 0
ı	Physic	ian	1. Decedent's Nam			or							2. Dete of Dee	eth	Yeer	3. Time of Deeth
J	/Med		Margare	et D. Sh	Oeilak	er							April	7, Dey 199	8	2:45 P.
J	Exami	ner	4e. Fecility Neme (i				r)				4b. City, To	own, or Le	ocation of Deeth	4c. County	y of Deeth	
Ľ			Statement of the last of the l	ll Menno					If Under	Vana			ille		rett	
ı	Funeral		5. Social Security N		. Sex 1 □ M 2		Age (In yrs. lest bi	rthday) Yrs.		Days		24 Hrs. Min.	(Month, De)			piece (Stete or Foreign ntry)
	Director		220-16- Usuel Residence of				82			_			April 2	28, 191	5 <u>Ma</u>	ryland
	yland		10e. Stete	10b. County			10c. City, Tow	n or Lo	cation						T.	10d. Inside City Limits
	r 28a-f show	ctor	Maryland	Ga	rrett				F	cie	ndsvi	lle				1∭ Yes 2□ No
	or 28	Oire.	10e. Street and Nur						10f. Zip (ntry?		
	death with the Meryland rns 23e or 28e-f show rinter be notified at	Funeral Director	704 Morri	is Ave.,	P. 0	 Box 	236			2	1531			U	SA	
	items items	une	11. Marital Stetus		Arn	ned Forces	t Ever in U,S.	13. \	Was Decede f Yes, speci	nt of i	Hispenic Or en, Mexica	igin? (Sp	ecify Yes or No- Ricen, etc.)	14. Red Bie	ce - Americk, White,	can Indian, etc.
20	0 0 0	by F	1 ☐ Never Marri 3 🕅 Widowed	led 2 Married	lf Y	Yes 2 2 es, Give			∏Yes 2					Specif		
21215-0020	72 hours "natural",		3 A Widowed	15. Decadent's		ar or Detes		Donor	lantin Herral	0000	nation			16b. Kind of B	AA11-	
215	C	Completed		ify only highest	grade comp			16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)							usiness/in	dustry
212	should be filed within ad Mentel Hygiene. marked other than "	E	Elementery/Seco	ndary (0-12)	Col	lege (1-4o	(5+)	Corr	espon	den	it			N	iewspa	aper
	e file othe vent,	Be C	17. Fether's Name		,						18. Moth	er's Name	e (First, Middle,	Meiden Sumer	ne)	
Vlai	should be ind Mentel I	To	William	n Dunham							Kat	hryn	Haenft.	ling		
Maryland	es 1 end 2 shou of Heelth end M filem 27 is mer ir other traumal		19e. Informant's Na	ame/Reletionship	(Type, Prir	nt)	196	. Mailir	g Address	Stree	end Numb	er or Run	al Route Numbe	r, City or Town,	State, Zip	Code)
	Heeith Heeith Jem 27 I			J. Spe	ar/Da	ughte					64, F	rien	dsville	, MD 2	1531	
Ore	Pages 1 nent of H int: If Itel		20e. Method of Disp	oosition Cremetion 3	□Remova	I from State	20b. Piece o cemete	f Dispo ry, cren	sition (Nemo netory or oth	er ple	ce)	i	Dete	20c. Location	- City or To	own, Stete
Baltimore,				5 Other (Spec			Steele							Friends		
Bal	permit. Departr Importu		21. Signeture of Fu	neral Service Lic	ensee			22	. Name end	Addre	ess of Fecili	ty Ne	wman Fu	neral H	omes	P.A.
	403 # W			Dear) Hun	noe	-	17	9 Mil	ler	St.,	Р.	O. Box	275, Gr	ants	/ille, MD 21536 Approximate
			23a. Pert1. Enter the shock, or heel	né diseese, or co nveilure. List on	mplications ly one ceus	that ceuse e on each	ed the deeth. Do line.	not ente	er the mode	of dyi	ng, such es	cardiec	or respiratory em	rest,		ILITALIANI DATMANI
Ď.	Physician /Medical		immediate Cause (Final											İ	Onset end Deeth
7	Examiner		immediete Ceuse (diseese or condition resulting in deeth)	n .	e. ch	roni	c lympho	cyi	tc leu	kei	nia					1 month
		ē				. II.	Due to (or es e									26
	d d ansit	Examiner	Consension in the line of		b	и по	dgkins 1		-							36 months
o,	certificate be executed iding physician end isse as the buriel-transit		Sequentially list cor if eny, leading to im cause. Enter Unde Cause (Diseese or that initieted events	es e consequence of):						-						
68760,	ite be iysicia ne bu	Medical	Cause (Diseese or thet initieted events	injury	C. Due to (or es a consequence of):											
89	certifice iding ph	Med	resulting in deeth) L	est			(-								į	
Box					d										1	
	0 0 0	Physician	Pert II. Other signific	cant conditions	contributing	to death	but not resulting in	n the ur	derlying cau	se gi	en in Pert I		23b. Did to	obacco use co	ntribute to	the cause of death?
P.0	requires that the been signed by th hould be detech		atherosc	lerotic	cardi	ovac	cular di	5021	so wit	h d	CODGG	- + i	1□ Y	es 2 🕅 No	3 Pro	bably 4 Unknown
ds,	res thet signed t	þ	acherosc	TETOLIC	cardi	Lovasi	culai ui	sea	SE MIC	11 (conges	SCIVE				
Records,	been si	Completed	heart fai	lure, in	naniti	ion d	ue to dy	spha	agia a	nd	aspin	catio	24e. Wes a perfor		ev	ere eutopsy findings ellebie prior to mpietion of cause
3ec	9 S C	id u									-				of	deeth?
a	T eg ag		of swallo		erial								1 □ Y	es 2 No	1 [Yes 2 No
Vital	Physician: The this certificate ral director, page	Be	25. Was case referr examiner?		Hospital:					Oth			(Check only or			
o		. To	1 ☐ Yes 2 ☐XI 27. Menner of Deeth			1 ☐ tnpat Dete of Inj		tpetien			4 57 140	-	me 5 Reside			y)
Division	Attending For deeth. ector: After by the funer	Certification:	1)\Q\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	5 Pending investigati		(Month, D	ey Yeer)	njury	м	. Injui Woi	rk? Yes 2□		200. 0000.00 11	ost injury coods	100	
Visi	if or Attendil efter deeth. Director: A d in by the fu	flea	3 Suicide	6 Could not determine	be 28e.	Place of In	njury - At home, fe	rm, stre					28f. Location (Si	treet end Numb	er or Rura	I Route Number,
ă	F 2 5 C	Sert	4 Homicide			building, e	fc. (Specify)						City or Town	n, Stete)		
	boun houn iners		29a. Certifier (Check only	1 Certifying F	hysician: 1	o the best	of my knowledge	, deeth	occurred et	the tir	ne, dete en	d plece, e	end due to the c	ause(s) end me	enner es s	teted.
	To the Hospital o within 24 hours eff To the Funeral DI completely filled in	ledical	one)	2	miner: On	the basis of manner s	of examinetion en	d/or inv	estigetion, in	my o	pinion, dee	th occurr	ed at the time, d	ate end piece,	end due to	the ceuse(s)
	With To To	Σ	29b. Signature and title of certifier 29c. License number 29d. Dete signed (Mon						d (Month,	Dey, Year)						
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		2	30. Neme end eddre													
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AM	Please Type or Print in Black Indelible Ink. Assure	All Cop
MARSHA	State of Maryland / Department of Health and	d Mental
STOKES	Items: 23 part I,27 per MEO G-758 4/24/98 reb Certificate of Death	
	1. Decedent's Nama (First, Middla, Last)	2. Data o

	Con	0	-	U	

29d. Dala signad (Month, Day, Yaar)

APRIL 16,1998

OK	ES	Ite	ems: 23 part I,27 p			4/24/98	3 reb Ce	ertificat	e of	Death			Reg. No.			
н	Physicia	n	Decedent's Nama (First, Midd	ila, La	st)							2. Data of De Month	Day	Yaar		a of Death
	/Medic		Marsha Renee										15,1998		082	6 A
	Examin	er	4a Facility Nama (If not institution							4b. City, Tov	wn, or Lo			of Death		
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1	Funeral		5. Social Sacurity Number	6. 5	ax □M2X7F	7. Aga (In yrs	s. last birthda Yrs.	Months			Min.	8. Data of Bir (Month, Da				ta or Foraign
	Director		219-74-8529 Usual Rasidance of Dacedanf			42	113.					12/8/5	5	Wash	ing	ton, D
	and wa		10a. Stata 10b. Count	У		10c. C	City, Town or	Location					10d. Insida City Limits			
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	72 hours after death with the Maryland natural", or items 23a or 28a-f show alsa Exams on must be notified a	Director	MD Cal 10e. Street and Number	ve	rt		usby	10f. Zig	Coda				10g. Citizan of	Whet Coun	try?	
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	fler of the control o	Funeral	1 □ Navar Marriad 20 Ma	rried	Armed Forcas? If Yas, specif					oan, Maxican,	, Puarto	Rican, atc.)	Bla	ck, Whita, a	atc.	
020	BF. 9	þ	3 ☐ Widowed 4 ☐ Divorce		If Yas, Gir Yaar or D	/a		1□ Yas	2 No	Spacify:			Specil	y: Af/	7. M	
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2121	d withir r than	Completed	11		oonoga (10101)	Del	i Cle	erk				Groce	rv		
b	al Hygi other	Be	17. Fathar's Nama (First, Middla	, Last)						18. Mother	r's Name	e (First, Middla	, Middla, Maidan Sumama)			
Maryland	0 2 0 0	0	William Rob	William Robinson Louise Maynard												
an	2 should and Men is marks surratic		19a. Informent's Name/Relationship (Typa, Print) 19b. Meiling Addrass (Straat and Numbar or Rural Routa Number, City or Town, St											, Stata, Zip	Code)	
	CENE		Woodward Stokes/Spause 255 Sachem Drive, Lusby MD 20657 a. Mathod of Disposition (Nama of 20b. Place of Disposition (Nam													
altimore,	as 1 and of Healt I Item 2		20a. Mathod of Disposition			20b.	Place of Dis	position (Nat	ma of othar pla	ice)	-	Date	20c. Location		wn, Stala	
Ĕ			1 ☐ Burial 2 ☐ Cramation 4 ☐ Donetion 5 ☐ Other (Mom	Gar	-dor	16	И	/20/08	Dunki	rle	MI	
alti	그 투 큰 증	So. Mem. Gardens 4/20/98 Dunkirk, No. 121. Signatura of Jonaral Service Licensee P.O. Box 121, Dunkirk, MD 20754												IK	MD	
ä	Depariment important													ome		
×		-	23a. Part1. Enter the disease of	r com	plications thus	aused the dec	ath. Do not a	P.O.	Box	121,	Du cardiac c	inkirk	_MD_2	0754	Approxi	nate
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	Physician /Medical		Immediata Causa (Final		ATHED	OSCLEROT	IC CAPD	TOVASCII	LADI	TEENEE						
	Examiner		disaasa or condition rasulting in daath)		a					JISEASE						
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	certificate be executed ding physician and use as the burial-transit	Examiner	Sequantially list conditions, if any, laading to Immadiala cause. Entar Underlying Causa (Disaasa or injury	1		Dua to	(or as a cons	aquance or):						1		
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O.	that the de ed by the detached	ys	Pert II. Other significant conditi	ona c	ontributing to di	eath out not ra	isuiting in the	undarrying o	ause g	wen in Pert I.			Yas 2 No			
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Sic	Attanding ir daath. ector: Afte by the fune	cal	3 ☐ Sulcida 6 ☐ Could			of laive. At	home for	1		, iaə 2UI		28f Location /	Street and Num	her or Pure	I Boute N	lumber
Division	or Attancattar daati aftar daati Director:	Certification:		nined	26a. Piece	of Injury - Ating, atc. (Spec	noma, ram, : pity)	erraat, tactor	у, оптов			City or To		our or mura	. riverte l'	
	ospital hours a unersi	ŭ	70a Cadillor 473 a	~	veleles: T- "	heat of mint	andad=- ·*		al 11 = 1	ima deta	d = la = =	and due to # -	anung(s) and		lated	
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29c. Licansa number

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State • Registrar

29b. Signatura and titta of certifiar

111 Penn Street, Baltimore, Maryland 21201

32. Ragistra's Signatura

32. Rayland Sawelson Rayland

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State of Maryland / D	epartment of	Health and	Mental	Hygiene	0

Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Data of Death 3. Time of Death Month **Physician** 28 1998 9:55AM Edmund Lewis Turner March /Medical 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 9 Kent Road Annapolis Anne Arundel 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. Birthplace (Stata or Foreign Country) 6. Sax ¥□ M 2□ F 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours Yrs. 216-30-1463 Director 65 Sept 21 1932 Maryland Usuel Rasidance of Dacedant the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylan Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modeal Examine must be notified at MD Anne Arundel Annapolis 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 9 Kent Road 21401 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □XYas 2 □ No 1955 — If Yas, Giva Yaar or Datas: 1980 Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Naver Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry United States Elamantary/Secondary (0-12) College (1-4or 5+) 12 Officer Navy 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Edmund Turner Virginia Lewis ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Carol Lewis Turner (Wife) 9 Kent Road Annapolis, Maryland 21401 20b. Place of Disposition (Nema of cematary, crematory or other piace) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 CxCrametion 3 ☐ Ramoval from State Metropolitan Crematory 3/31/98 Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Addrass of Fecility ohn M. Taylor Funeral Home, Inc. 21. Signatura of Funaral Sarvica Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 our 23a. Part1. Entar the disaasa, or complications that caused the death. Do not antar the mode of dying, such es cardiec or raspiretory arrast, shock, or haart failure. List only one cause on each line. Physician /Medical Cacheria of malignamore Immediata Causa (Final 3000 disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of):

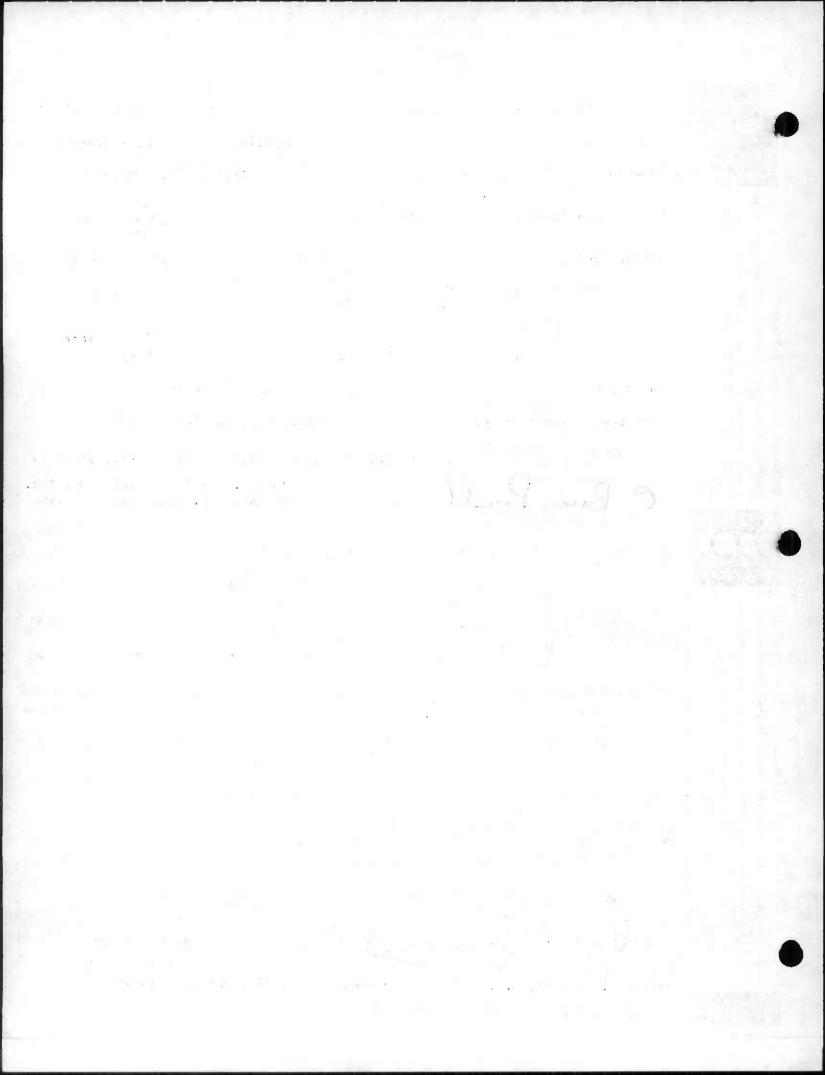
Right Cerebral Dysfunction

Due to (or as a consequence of):

Me tas TATIC to lung and Brown Examiner attending physician and for use es the burial-trensit be executed Sequentielly list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initiated evants rasulting in death) Last Box 68760. Physician/Medical The law requires that the death certificate vant -ling Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part f. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed has certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Mospital or Attending Physician: 124 hours effer death.
 Funeral Director; After this certifical letely filled in by the funeral director; p. 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa SON Rasidance 6 Othar (Specify) 10 1 ☐ Yas 2XXNo 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascriba how Injury occurred Certification: 28b. Tima of 1 Natural 2 Accident 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not be daterminad 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 281. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 | Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifian Medical pletely (Check only one) To the I within 2 To the I complet 29b. Signature and the of certifian 29c. Licensa number 29d. Data signed (Month, Dey, Year) March 30, 1998 D08314 (410-268-3232)30. Name and address of porson who complated causa of death (Itam 23a) (Type, Print) 205 Ridgley Avenue Annapolis, Maryland 21401 M.D. George C. Samaras, 32. Registrar's Signatura

Juna Davidson-Randelle 31. Data fliad (Month, Day, Yaar) State APR 02 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth April 10, 1998 **Physician** HAZEL CECELIA DUNNINGTON TAYLOR 9:55A /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months 1□M 2QF 73 Yrs. 214-28-9276 JULY 21, **Director** MARYLAND 1924 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director MARYLAND CHARLES INDIAN HEAD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 traumatic event, the Medical Examiner must be 238 5250 RED HILL DRIVE 20640 UNITED STATES Funeral 12. Wes Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 8 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ⊠ Widowed 4 □ Divorced BLACK Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry outd be filed within 72 and Mental Hygiene Elementary/Secondary (0-12) College (1-4or 5+) 10th HOUSEWIFE N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MARCELLUS DUNNINGTON ADA PENNY DUNNINGTON 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zlp Code) Important: If them 27 is any injury or Pages 1 and 2 HOWARD TAYLOR 15607 HENRIETTA DRIVE ACCOKEEK, MARYLAND 20607 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State ST. CHARLES CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 4/15/98 GLYMONT, MARYLAND 21. Sign ture of Funeral Service Licenses 22. Name end Address of Fecility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD THORNTON JOHNSON INDIAN HEAD, MD 20640 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** SMAIL BOWEL INFARCTION/ISCHEMIA2

Due to (or es e consequence of):

MESENTERIC EMBOU'

Due to (or as a consequenca of): /Medical Immediete Cause (Finel disease or condition resulting in death) **Examiner** Examiner if or Attending Physician: The law requires that the death certificate be executed effect death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be deteched for use as the buriet-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest ATHEROSCIEROTTIC CARDIOVASCULAR DISEASE P.O. Box 68760, Physician/Medicai Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably > ☐ Unknown MYOCARDIAL INFARCTION Division of Vital Records, þ 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? RENAL INSUFFICIENCY 2KINO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Appatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours of To the Funeral D completely filled 112 Certifying Phyeiclen: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. Medicai 29a. Certifier 29b. Signature and tale of cartifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Waldorf,Maryland 20602 Ashvinkumar J. Patel, MD Preston Square II 6B Industrial Park Dr. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State APR 1 4 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			State of Marylan	-	tificate of			Reg. No.	6.0		
Physic		Decedant's Name (First, Middla, Las WILLIAM EVERET	T THORNE, JR.				2. Data of De Month April	Day	Yaar 998	3. Time of Death 7:00AM	
/Med Exami		4a. Facility Nama (If not institution, give				4b. City, Town, or Loc				7:00AM	
LABITI	1161	Civista Medic				La Pla	ta		arles		
Funera Director		Social Security Number 6. Security Number	ex 7. Aga (In yrs.	last birthday). 3 Yrs.	If Undar 1 Year Months Days		8. Date of Bir			ce (Stata or Foreign YLAND	
g & m		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d	I. Insida City Limits	
the Maryla 28a-f shor notified at	to	MARYLAND CHARLES	E	BRYANS	ROAD					1 ☐ Yes 2 No	
th with the M 23e or 28e-f ust be notifie	Funeral Director	10e. Street and Number 6815 INDIAN HEAD	HIGHWAY		10f. Zip Coda 20	0616		10g. Citizan of V U.S	Vhat Counfry	n	
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d 212 filed with Hygiene, ther ther		17. Father's Nama (First, Middle, Last)				18. Mothar's Nama (First, Mid			a)		
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumetic event	To Be	WILLIAM EVERETT 1	THORNE			NORA		Wolden Comen	α/		
shou man	F	19a. Informant's Name/Ralationship (7		19b. Mallin	g Addrass (Strae	and Number or Rura		er, City or Town,	Stata, Zip Ci	ode)	
C 72 NV 64		CATHERINE DENT THO	RNE/WIFE	6815	INDIAN	HEAD HIGHW	AY BR	YANS ROA	AD. MD	20616	
Baltimore, semil. Pages 1 as Separtment of Hea montant: If Item: my injury or other ance.		20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify	20b. P Ramoval from Sfate	lace of Disposematary, cram	sition (Name of latory or othar pla	ce) GARDENS A	Data	20c. Location -		n, State	
Balt parmit Departm imports any inja		21. Signature of Funeral Service (Onsaa 22. Nama and Addrass of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND								04	
		23a. Part1. Entar tha disaasa, or comp shock, or haart failure. List only of		n. Do not anta	r tha mode of dyi	X 156, WAL ng, such as cardiac or	respiratory e	MAKYLANI rrest,	A	pproximeta nterval Between	
Physician /Medical Examiner	er	Immediate Causa (Final disease or condition rasulting In death)	a Netest	atic r as a consequ	Come	r of (Janu	us	Ö	Disat and Death	
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in death) Last	С.	r as a consequ	The same					7 H	
BOX Seath cert attendin	iciar	Part II Other elemidicant conditions as	estibution to death but not unco	ulain en inn ab en une		un la Dant I	ook Did				
Ords, P.O. BOX 6 requires that the death certific een signed by the attending p	Phys	Part II. Other significant conditions co	Service of the second s	ating in tha un	danying causa gr	van in Part I.		Yes 2 No		he cause of death? bly 49 Unknow	
2 s b	Completed by Physician/N							24a. Wes an autopsy performed?		24b. Wara autopsy findings availabla prior to completion of causa of deeth?	
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Of Vital Physician: The this certificate ral director, pag	Be	25. Was casa rafarred to medical examinar?				26. Place of Death	(Check only o	ла)			
Physic Physic this c	2	1 Yas 2 No	,	ER/Outpatient	3LI DON	nar: 4□ Nursing Hom					
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Certification:	27. Mannar of Death 1 Natural 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo M 1 □	Yes 2 □ No		now injury occurr			
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To th Within To th	×	29b. Signature and fitle of certifiar	- Brule W	1	29c. Licans	1009		29d. Data signed	(Month, Da		
7		30. Nama and address of person who c	ompleted ceuse of daeth (Item	23e) (Type, F						20646	
St		Henry Burke, MD 31. Data filed (Month, Day, Yaer)	115-A La Gr 32. Registrar's Signat 1998	ture.		P.O. Bo	x 2539	9 La P1	ata,	Marylan	
Regist	al	WLU 7 -	1000 June 10"								

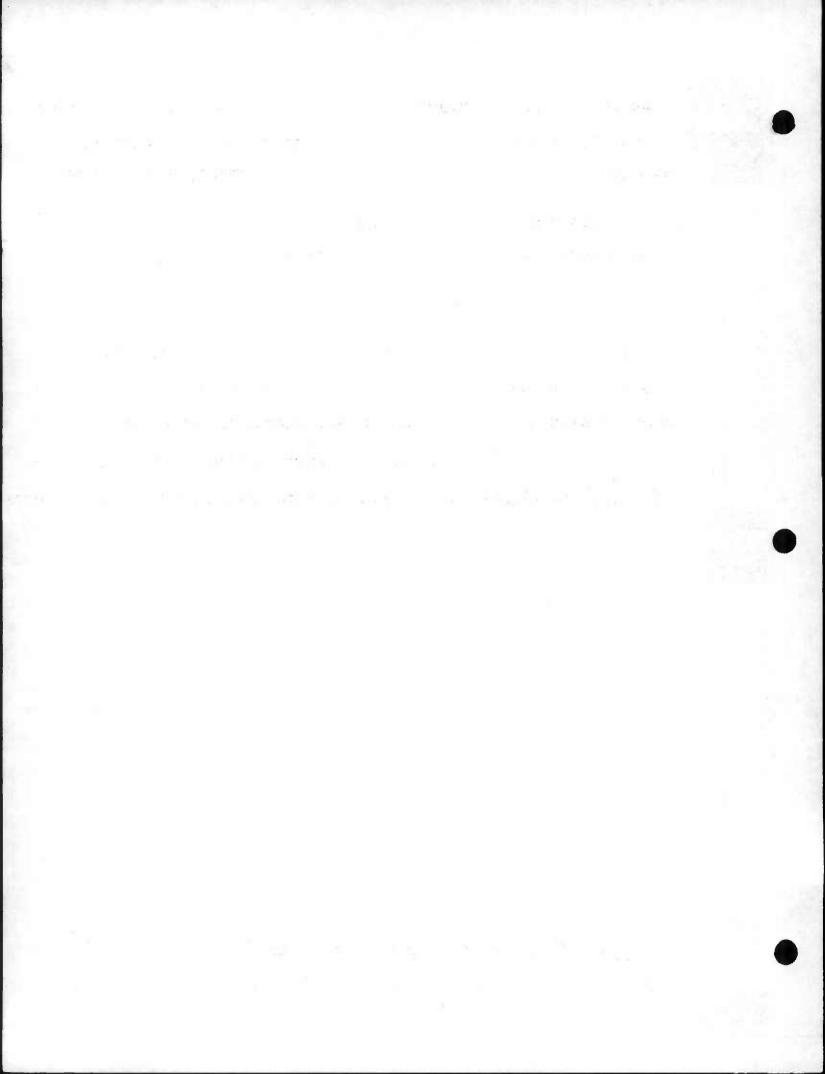
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 10 Dey V. PAULINE TRADER APRIL 1998 10:26 P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 108 HEARTWOOD DR. SALISBURY WICOMICO 8. Date of Birth (Month, Day, Year) JULY 31,1915 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Months 1 □ M 2 🕽 F Deys Hours Min Yrs. MARYLAND Director 216-09-6133 Usual Residence of Decedent the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 ☐ Yea 2 No Director WICOMICO MD SALISBURY 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with 108 HEARTWOOD DR. 21804 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: é 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within the end Mentel Hygiene.
7 Is marked other than ** Elementery/Secondary (0-12) College (1-4or 5+) FLOOR SUPERVISOR SEWING FACTORY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVIS 2 ALONZA **EMMA** MERRITT F. 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2: Depertment of Heaith er Important: If Nem 27 Is any Injury or other trau ROGER BROMLEY - SON 108 HEARTWOOD DR. SALISBURY, MD 21804 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) SPRINGHILL MEMORY GARDENS 4-15-98 HEBRON, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 705 E. MAIN ST. BOUNDS FUNERAL HOME uala SALISBURY, MD 21804 241. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete ntervei Betw Onset end Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner buriel-transit that the deeth certificete be axecuted Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or as a consequence of): Box 68760, attending physician for usa as the bune 1 Physician/Medical Due to (or es e consequence of P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was an eutopsy performed? Completed peen has After this certificate 1 ☐ Yes 2 HO 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certification of the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director of the funeral director. 25. Wes cese referred to medical Be 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 🗌 Yes 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred 1 Weturel 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 \ Homicide 29e. Certifier Dertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. Medical 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed 10th St; Pocomoke, MD Charles ubs 305 31. Dete filed (Month, Day, Year) State

State of Maryland / Department of Health and Mental Hygiene

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3	/Medi Examii		4e. Facility Name (If not institution		THOMPSON	DI.		4b. City, Town, or Lo		1	4c. County of Death	
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н	Funeral		5. Social Security Number		ge (in yrs. last bir	thday) If U	nder 1 Yeer	BISHOP' If Under 24 Hrs.			CESTI 9 Birthoi	
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	yland		10a. State 10b. County	1	10c. City, Tow	n or Location					10	0d. Inside City Limits
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21215-0020	n 72 hours "natural",		15. Deceder	nt's Education		Decedent's	Usual Occup	pation		16b. Kind of Bu	usiness/Ind	Justry
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	f Haaith ftam 27		MARIE THOMPSON	/WIFE	P	.O. BO	X 502	, SELBYVII	LLE, DEL	AWARE 1	9975	
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Baltimore,	permit. Page Department o Important: If i any Injury or once.		21. Signature of Funeral Service	Licensee				ess of Facility	7 2 9 7 9 9 1	JEINGLE V.	LDDD	DEBRINRE
œ	88 = 58		12.0	Mark		HAST	TNGS I	FIINERAL HO	OME. SEL	BYVILLE	DEI	LAWARE 1997
			23a. Pert1. Enter the diseese, o shock, or heart feilure. Lis	r complications that cause	ed the death. Do r						, ,	Approximate
	Physician /Medical		snock, or neart tellure. Lis	only one cause on eech	line.	,		. /	,		i	interval Between Onset end Deeth
ч			Immediate Cause (Final disease or condition Conglistive Heard Fachese								İ	1 rest
	Examiner		resulting in death)	A	Durato for as e	000000000000000000000000000000000000000	100:	11000	, au	are	1	1201.
		ner			Phone		on d	Parte			1	A month.
	tificata be axecuted ig physician and as the burial-transit	Examiner	Sequentially list conditions	C .	Due to (or as a	consequence	ol):	1 cill	<i>x</i> C			0 11
ó	an ar		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	1	/			0	month,		
68760,	ta be ysici	cal	Cause (Disease or injury that initiated events	0	Due to (or as e o	consequence	of):	grey				
	\$ 00 a	Aedical	resulting in death) Last	L and a		,						
Box	The law requires that the death cert tile has been signed by the attendin page 2 should be detached for use			d							1	
	deat	Physiclan/	Part ii. Other significant conditi	one contributing to death	but not resulting Ir	n the underlyi	ing cause giv	ven in Part I.	23b. Did to	obacco uee cor	ntribute to	the cause of death?
P.0	that tha de led by the a detached	h.	1.		*				1 🗆 Y	ee 2□ No	3 Prob	ably 4 Onknown
	as that igned i	by F	174	por Tensi	on							
Records,	v require been sign								24a. Was a	n autopsy		re autopsy findings illable prior to
S	s be	Completed							porior	111001	CON	noletion of cause death?
æ	The law ate has page 2	E							1 U Y	es 2DNo	10	Yes 2 No
Vital		BeC	25. Was case referred to medical					28. Piece of Deet				, , , , , , , , , , , , , , , , , , , ,
>	Physician: this cartific ral director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospitai:	ient 2 ☐ ER/Ou	toatient 3	DOA Oth	an.	me 5 Reside		er (Snecihi	,)
of		n: T	27. Manner of Deeth	28a. Date of In	ury 28b. 1	Time of	28c. Injui Wo		28d. Describe h			/
0	Attending I r daeth. ector: Aftar by the fune	atio	1 ☑Natural 5 ☐ Pendii 2 ☐ Accident invest		By Year)	njury M		Yes 2 □ No				
Division	or Attendi after death. Director: A I in by the fu	Hice	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Flace of I	njury - At home, fa	rm, street, fac	ctory, office		28I. Location (S	treet end Numb	er or Rural	Route Number,
Ö	s after	Certification:	4 Hollicide	building, e	tc. (Specify)				City or Town	n, Stete)		
	To the Hospital or / within 24 hours after To the Funeral Direct completely filled in the Funeral or / within the funeral property of the funeral property filled in the funeral property of the funeral filled in the funer	-	29e. Certifier 12 Certifyli	ng Physician: To the best	ol my knowledge	, death occur	rred et the til	me, date and place,	and due to the c	ause(s) and me	nner as sta	ated.
	the H in 24 the Fi	edical	one) 2 Medical	Examiner: On the basis end menner s	tated.	wor investiga	ttion, in my c	pinion, death occur	ed at the time, d	ate and place,	and due to	tne cause(s)
	To To Coo	Y	29b. Signeture end title of cartifie		1/		29c. Licens			9d. Date signed	(Month, L	Dey, Year)
	IH	r	Denes	5 1./	fax 1	40	D	-2005	0	1	4/8%	198
	< 1\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		30. Name and address of person	who completed ceuse of		Type, Print)				111	, ,,	
,	27.		BENITO &	S- CHAN	547	- G,	River	-2005	2. So	lisby	, 14.	18/5 d
	Sta	te	31. Date Ilied (Month, Day, Year,	32. Regis	tar's Signature	ıı	100			//		7
	Registr	ar	APR 0 8 199	16 Salva a Ru	WAN INDIVIDUAL	1						



Item: 23 part I,per MEO G-759 5/20/98 reb Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 0

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/	75	/	/
 St. on	2.1	Day	Shares

SIMMON	
WRIGHT	

Physicia /Medica Examine

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "naturat", or Items 23a or 28a-f show any Injury or other treumetic event, the Medical Examiner must be notified at BDBs.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

ata has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

1. Decedent's Neme (First, Middle, Last)						2. Date of D Month		Year	3. Time of Death
SIMON H. WRI	GHT JR.					MARCH		98	6:07A.M.
4a Facility Name (If not institution, give s	treet end number)			4b	. City, Town,	or Location of Dee	th 4c. County o	f Deeth	
UNIVERSITY SHOCK T	RAUMA UNIT				BALTIM		CITY		
5. Social Security Number 6. Sex	M 2 F	s. last birthday)	Months		If Under 24 I Hours N	fin. 8. Date of B	irth ley, Yeer)	9. Birthp	leca (State or Foreightry)
225-84-8267 Usuel Residence of Decedant	39	Yrs.				MARCH	23 1960	VIRG	INIA
Oa. State 10b. County	10c. (City, Town or Li	ocation					1	0d. Inside City Limi
MADWI AND ANNE ADIN	DEL	DUDDN							1X Yes 2□N
MARYLAND ANNE ARUN Oe. Street end Number	DEL S	SEVERN	10f. Zip C	ode			10g. Citizen of W	het Coun	itry?
8345 CANDLEWICK CO	TRT			2114	4		US		
	2. Wes Decedent Ever in	U,S. 13.	Was Decede	nt of His	panic Origin	(Specify Yes or N	o- 14. Race		an Indien,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No					uerto Rican, etc.)		, White,	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2)	KI NO	Specify:		Specify:	BLA	CK
15. Decedant's Educ (Specify only highest grede	ation completed)	(Give	edent's Usual	done du	ion ring most of	working	16b. Kind of Bus	sinass/Inc	dustry
Elementery/Secondary (0-12)	Collage (1-4or 5+)	lifa.	DO NOT use	retired)			COSSENTI	NO C	ONTRACTIN
12th	2 yrs.	CC	ONSTRUC			Nama /First Middle	INC.	.1	
7. Father's Name (First, Middle, Last)								"	
SIMON H. WRIGHT		105 84-11	lina Address (Ctront		MAE DAV	IS ber, City or Town, S	State 7:-	Code
19a. Informent's Name/Relationship (Ty)	re, rimij								C006)
WANDA POOLE Oe. Method of Disposition	20b	Plece of Disp	osition (Nama	a of		Date	N, MD. 21		wn, State
XXX Burial 2 ☐ Cremetion 3 ☐ R	emovel from State	NE LEVE				4/3/98	CAPRON,		
4 ☐ Donation 5 ☐ Other (Specify)			22. Name end	Address	of Cooling				
1. Signature of Puneral Service Licanse						MORTUARY	. P.A.		
Lavy D.	Reese	82	21 WEST	r st	. ANNA	POLIS, M	0. 21401		
Sequentially list conditions.	Jue shit Due to	(or as a conse		/					
of any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury									
that initiated events resulting in death) Lest	Due to	(or es e conse	quence of):					1	
d									
						005 01		A-14A A-	Mr
Pert II. Other significant conditions con	tributing to death but not re	esulting in the t	underlying cat	use giver	ı in Part i.		i tobacco use con Yee 2□ No	3 Pro	
							100 2010	0	A Comment
							s an autopsy formed?	ev	ere eutopsy finding ailabla prior to mpletion of cause death?
						1X	Yes 2 No	1)	Ves 2□ No
25. Was case referred to medical axaminer?					26. Place of	Death (Check only	one)		
1 X Yas 2 No	ospital: 1X Inpatiant 2	☐ ER/Outpatie			4 LI NUISI		sidenca 6 □Otha		y)
7. Mannar of Death 1 □ Natural 5 □ Pending	28a. Deta of Injury (Month, Day Year)	28b. Time of Injury	of 28	c. Injury Work		28d. Describe	how injury occurre	ed	
2 Accident investigation	3127198	0100 H	RM		es 2 No	Sabyel	18608		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Injury - At building, etc. (Spe	homa, farm, st	traet, factory,	office			(Street end Number own, Stete) Pres		Al Route Number
(Check only 2V Medical Examin	Iclan: To the best of my ker: On the basis of exami	nowledga, deat	th occurred et	t the time	, date and p	lace, end dua to the	e ceuse(s) and mar a, date and place, a	nner as s	dated. o tha causa(s)
one) 29b. Signature end title of certifier	end menner stated.		290	License	number		29d. Date signed	(Month.	Dey, Year)
	V						MARCH 30		
Weoden M. 1	us for			.C.M	. C.		PIARCH 30	J, 133	70
30. Nama and addrass of person who co	mplated cause of death (tt	lem 23a) (Type	, Print)						

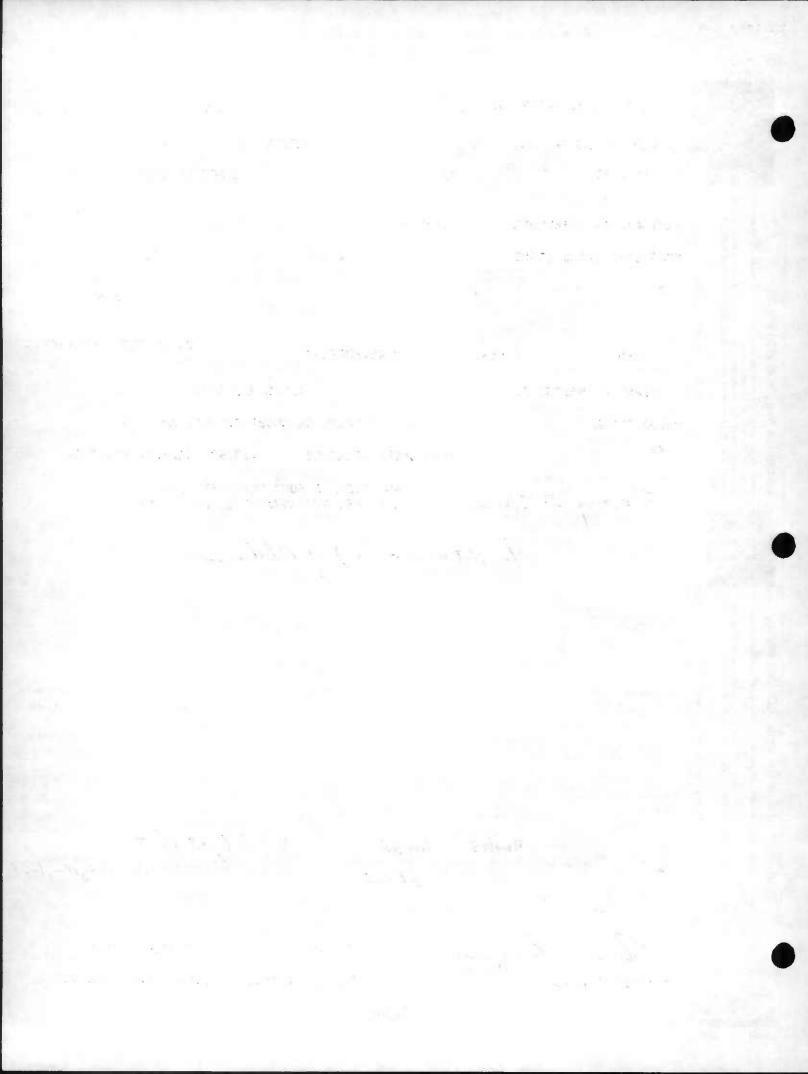
State Registrar

31. Data filed (Month, Day, Year) APR 0 3 1998

Theodore King M.D.

32. Registrar's Signature lia Savidson-Randelle

111 Penn Street, Baltimore, Maryland 21201



98-1764-009 ΔM **ANDREW** WATT

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

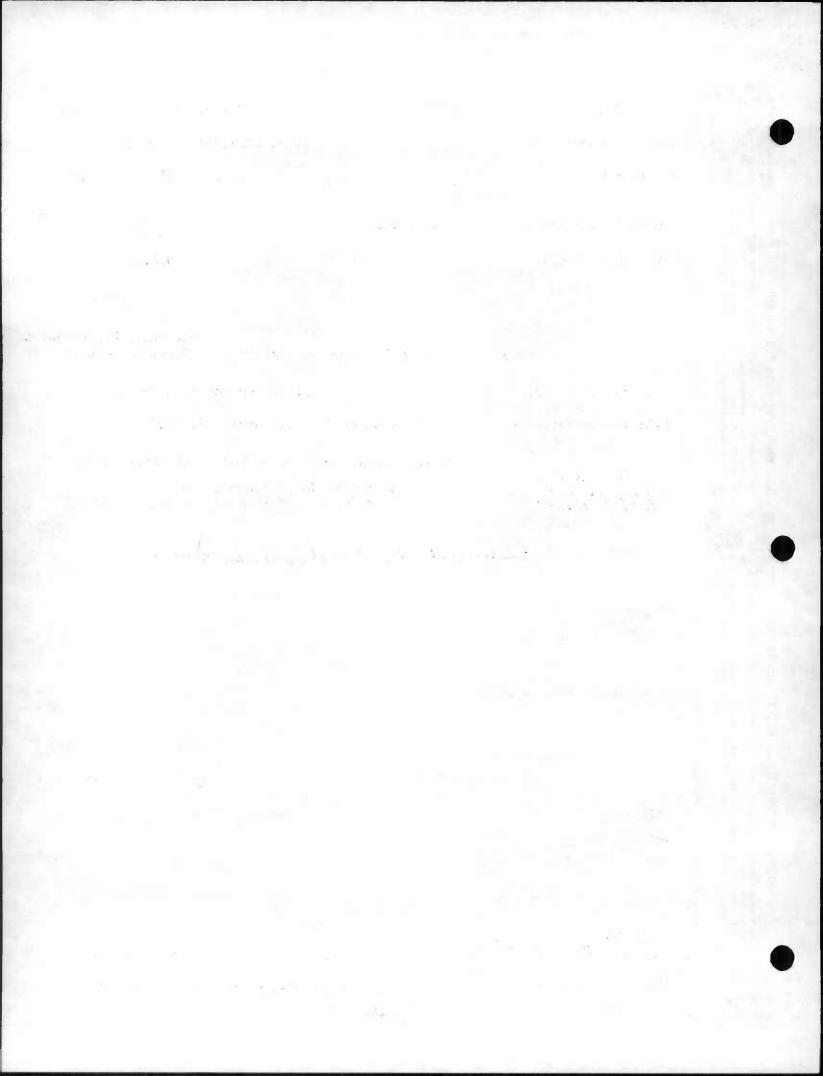
State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Dey **Physician** Watt IV Andrew MARCH 29, 1998 11:06 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Nama (If not institution, giva street and number) **Examiner** CALVERT MEMORIAL HOSPITAL Prince Frederick if Undar 1 Yaer | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) **Funeral** Min 1X M 2□ F Months Days Hours Yrs. 219-48-9849 49 **Director** New York Usual Rasidenca of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at page. 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 1349 Shore Drive 21037 .S.A. 14. Race - Amarican Indian, 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, White, etc. 1 ☐ Naver Married 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yas 2 🗓 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) Maryland Department of College (1-4or 5+) Elementery/Secondary (0-12) 5+ Juvenile Justice Howard County Supervisor 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Neme (First, Middle, Last) Be Andrew Watt, Jr. Ethel Josephine Boardman 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Linda Jeanne Watt/Wife 1349 Shore Dr. Edgewater, Md. 21037 20b. Plece of Disposition (Nema of cematary, crematory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 4-2-98 Alexandria, Virginia Metropolitan Crematory 22. Nama and Addrass of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md.21037 unco 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximate Interval Batween Onset end Deeth **Physician** Immediata Causa (Final disaasa or condition resulting in daeth) /Medical Examiner Due to (or es a consequance of): Examiner physician and the burial-transit certificate be executed Saquentially list conditions, if any, laading to immadiata causa. Enter Undarfying Causa (Disease or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequenca of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 98 nse Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Division of Vital Records, þ 24b. Wara autopsy findings evailable prior to 24a. Was en autopsy performed? Completed complation of causa of deeth? page 2 s has 1 Xes certificate or Attending Physician: 25. Was casa rafarrad to madical axaminar? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatiant Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1XXYes 2 No 2 X ER/Outpatient 3□ DOA After this 28a. Data of Injury (Month, Day Year) funeral 27. Mennar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 Yas 2 No 24 hours efter deeth.

Funeral Director: A investigation 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 Suicida Plece of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Cartifiar t Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and plece, end dua to tha causa(s) and mannar as steted. edical completely Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and menner steted. (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME MARCH 30, 1998 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) THEOSORE Miking 111 Penn Street, Baltimore, Maryland 21201

State Registrar

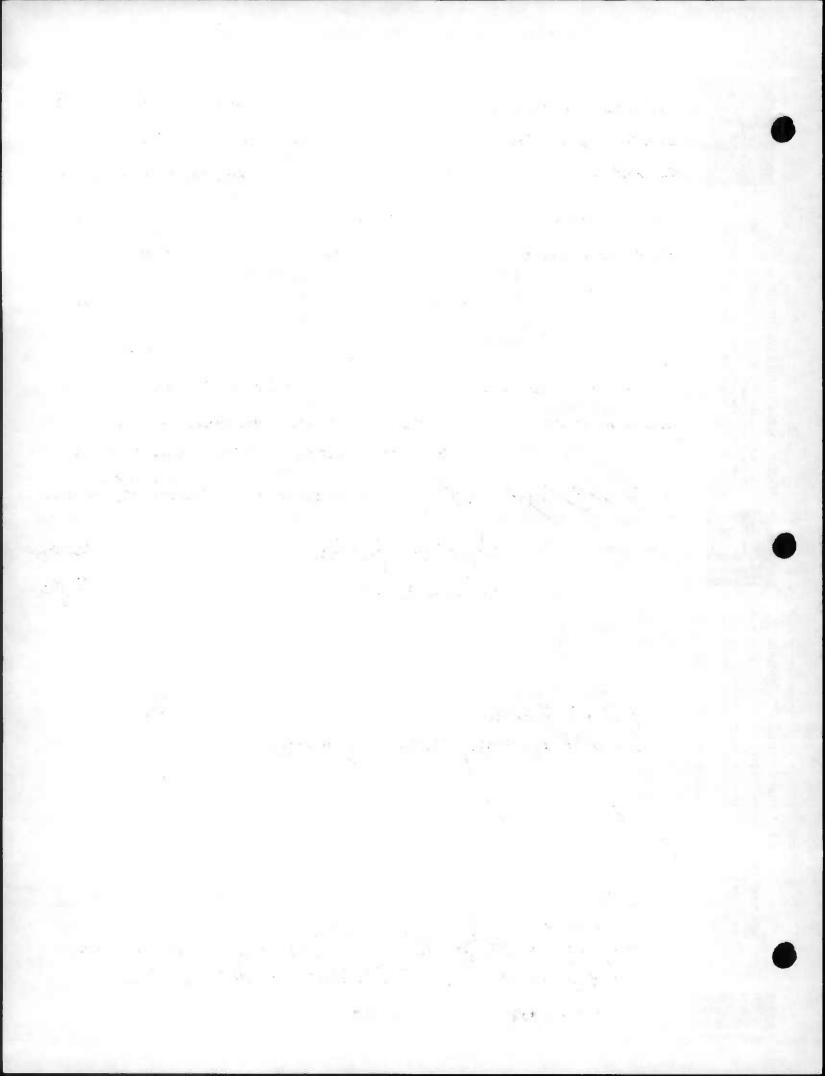
R 01 1998

32. Registrar's Signatura
Saka Dawdson-Randelle



					State	of Ma	ryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>			Reg. No.	1 6	024	
	Dht-t		Decedent's Name (First, Middle, Last)							2. Dete of Dea Month		Year	3. Time of Deeth	
	Physicia /Medic		. Tambe Patri Wilkinson Te							APRIL 1	2, ^{De} 1998	2115		
	Examin		4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth											
			Sacred He	red Heart Hospital					ind	Alleg				
	Funeral		5. Social Security Nu		Sex 15√2M 2□ F	7. Age	(In yrs. lest birthday)	Months Deys			h y, Year)	9. Birthpi Coun	lece (Stete or Foreign try)	
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	pue *	- }	Usuel Residence of I	10b. County			10c. City, Town or Le	ocation				1	0d. Inside City Limits	
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	the 28	9	10e. Street and Num		-			10f. Zip Code	_			Whet Coun	try?	
	3a or	Funeral Director	418 Mary	land Av	enue			2156	52		United	Stat	es	
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0	2 should be filed within 72 hours after death with the Maryland end Mantel Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner mant be northed.	프	1 Navar Marrie	d 35 Marrie	Armed F	2 No			ben, Mexican, Pue Specify:	erto Hican, atc.)		k, White,		
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12	be filed withintel Hygiene. d other than		12		-41		Luk	ricator	40 Manhada M	ame (First, Middle,				
anc	be fill be fill be fill be out	Be	17. Fathar's Nema (F			_				ame (Filst, Mildle,		10/		
7	12 should be filed within h and Mentel Hygiene. 7 is marked other than traumatic event, trails.	2			nson, Si	L .	10b Maili	na Address /Ctro		Rurel Route Number		Ctata 7in	Code	
Maryland			19e. informent's Nar Marion W							ternport		1562	0006)	
	Health Health lam 27	1	20e. Method of Dispo		11		20h Place of Disp	osition (Neme of		Dete	20c. Location -		wn, Stete	
Baltimore,	permit. Peges 1 end Depertment of Health Important: If Itam 27 any injury or other to once.		1 ☑ Burial 2 ☐ 4 ☐ Donetion 5	Cremation 3		State	St. Pete	r's Ceme	tery	4/15/98	Western	port	, MD	
Ball	Depert Import any in		21. Signature of Fun	erel Service Lid	aspe	. (// //	2. Name end Add	ress of Fecility eral Home		1 Church sternpor		D 21562	
			23a. Pert1. Enter the shock, or heert	e diseese, or co	omplications that	caused to	he deeth. Do not en	ter the mode of dy	ying, such es cerdi	ac or respiretory e	rrest,	T	Approximete Interval Between	
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	/Medical		Immediete Ceuse (F diseese or condition		/	HED	who	Halle	re				DWEKS	
1	Examiner		resulting in deeth)		0.	P	ue to (or as e conse	quence of):					Duseks Duseks	
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	the deeth certificete be executed by the attending physician end sched for use es the bunel-transit	Examiner	Sequentially list conditions to improve	ditions,		D	ue to (or es e conse	quence of):				1	U	
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n of	g Ph ter th neral		27. Manper of Deeth	5 Pending	28e. Date (Mo	of Injury	Yeer) 28b. Tima o	of 28c. Inj	ury et ork?	28d. Describe	how injury occur	red		
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Division	r Atterdering	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	289. PIB	e of Injur	y - At home, farm, st (Specify)	reet, fectory, office	Θ	28f. Location (oer or Rura	Il Route Number,	
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check one)		aminer: On the		my knowledge, deal examination end/or Ir ed.							
	With Com	Σ	29b. Signature and t	the of certifier	GOV	the	HMD	29c. Dige	nse number) Dh Z	23	APRIL	2	Dey, Year)	
	+ (VA	-	30. Neme end eddre	ss of person w	no completed car	use of det	(Item 33e) (Type	griding 11 Des	agrico)	ND:	2/10	2	. , , , ,	
	Sta	te	31. Data filed (Month	, Day, Year)	32.	Registrer	's Signature		3.00		<i>y- y- y- y- y- y- y- y-</i>			
611	Registr	ar		APR 1	4 1998	Jak	is discovered	adul						

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State of Maryland / Department of Health and Mental Hygiene

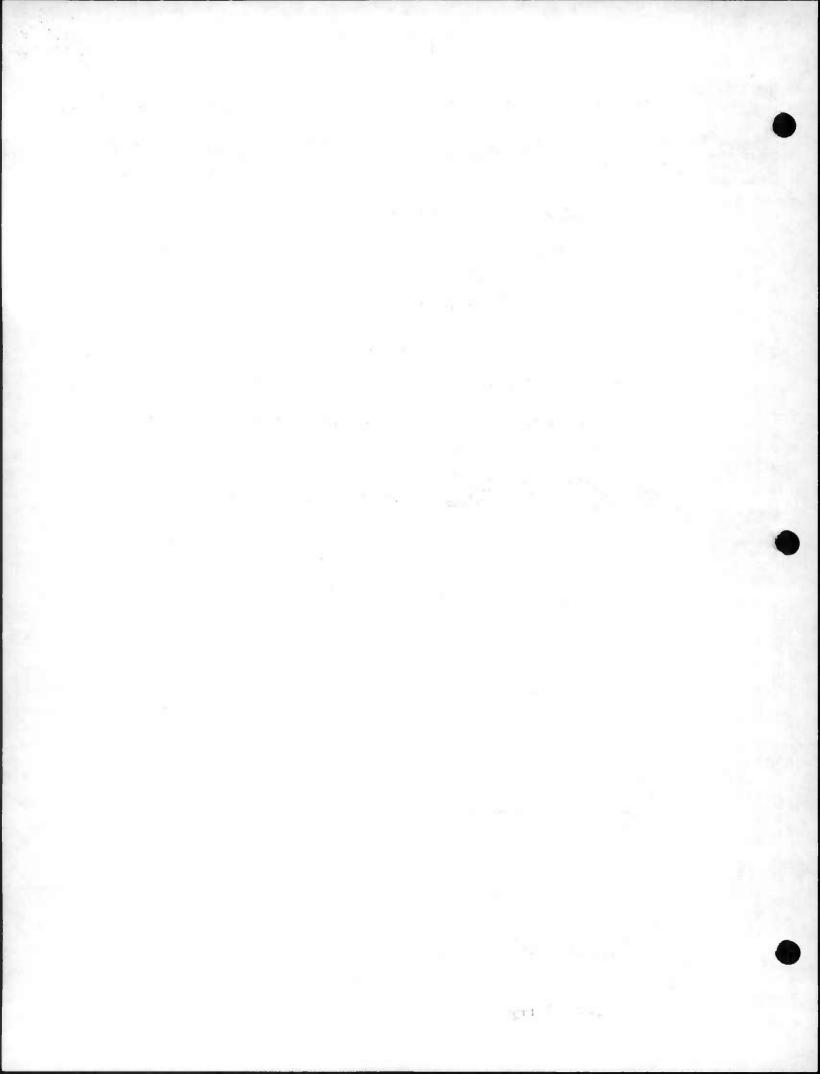
Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Daeth 3. Time of Daeth Month Dey **Physician** WALTER HANCE WILLIAMS, JR. APRIL 11, 1998 1800 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Memorial Hospital Prince Frederick
If Under 1 Year | If Under 24 Hrs. | 8. Date of Bird 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) March 2, 1925 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 ★M 2 F Deys Hours 215 18 3780 73 Yrs. Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Health end Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumatic event, the Medical Examinar must be notified as 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits MD Calvert Owings Director 1 Yes XX No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6750 Briscoe's Turn Rd. 20736 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Raca - American Indien, Bleck, Whita, etc. 1 XYes 2 No If Yes, Give Yeer or Detes: 1942-45 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedent's Education Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Carpenter Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Walter Hance Williams, Sr. Madeline Walsh 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Alberta E. Williams/wife same as 10 above 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Mt. Harmony UMC Cemetery 4-15-98 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or once. Owings. MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Inc 22. Name end Address of Fecility Rausch Funeral Home, Owings, MD 83a. Pen1. Enter the disaasa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final Aspiration preumonia

Dua to (or es e consequenca of): diseese or condition rasulting in death) **Examiner** Examiner Cerebro vascular or Attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the ettending physician and Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Undarlying Ceuse (Diseesa or Injury that initleted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): signed by the etten Id be deteched for u Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en autopsy partormed? 1 Tyes 2 No Be 25. Was casa refarred to madical 26. Placa of Death (Check only ona) 1□ Yes 30 No Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 12 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Magner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigetion 1 Naturel 1 Yas 2 No 2 Accident completely filled in by the 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours e NO Certifying Physician: To the bast of my knowledge, deeth occurred et the time, deta end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred et tha time, date end place, end dua to the cause(s) end menner statad. edicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end addrass of person who complated cause of death (Item 23e) (Type, Print) JA 10 Dr. David J. Tardio, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signetura State Jalia Davidson Randall Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene R 1 2 0 2 7

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APR 13 1998 Jahr Museum Randall

State Registrar

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State of Maryland / Department of Health and Mental Hygiene | 2828

			Amend #7 WCHD 4/10/98			Cei	tificate of	Death		Reg. No.		
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	41		JOHN T. BULKEL					SALISBU	RY MD 2	1801		
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	Certificate of Death	Reg. No.	
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1. Decedent's Neme (First, Middle,

Curtis

William

Day 18 April 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Fork 4110 Ravenhurst Circle Baltimore 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** 10 M 2□ F Months Days Hours Min. 89 Yrs. 214-03-8045 Director December 28,1908 Mississippi Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercise must be notified at 10c. City, Town or Location 10b. County 10e Stete Parkville Baltimore Directo maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 8800 Walther Blvd. 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 Never Merried 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White à 3 Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NIH nemist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Carrie L. Curtis ouis F. Alford 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) William C. Alford, Sr. FORKIMD 21057 4110 Ravenhurst Circle 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition April 20 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eenmount Crematory
22. Name and Address of Facility, 21. Signature of Funeral Service Licensee Evans FUNERal 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8800 Hartord Rd. **Physician** /Medical Immediate Cause (Final FAKURE 14 GART CONGESTIVE disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be assecuted Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): for use as t been signed by the a should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown FAILURE λq Completed 24e. Was en autopsy GURYSM certificate has b 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 Yes 2 1 2 No Other: 4 ☐ Nursing Home 5 ☐ Aesidenca 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a

29a. Certifier (Check only one) Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of eath (Item 23e) (Type, Print) D Robert State Registrar

Wiedefeld 31. Dete filed (Month, Dey, Year) APR 23 1998

3346 Papermill Rd. no 0. 32. Her this signature

001000

29c. License number

DHMH 16 Rav 6/95

To the Hosp within 24 hos To the Fune completely fi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) 29d. Dete signed (Month, Dey, Year)

2:00 AM

Birthplece (State or Foreign Country)

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10d. Inside City Limits

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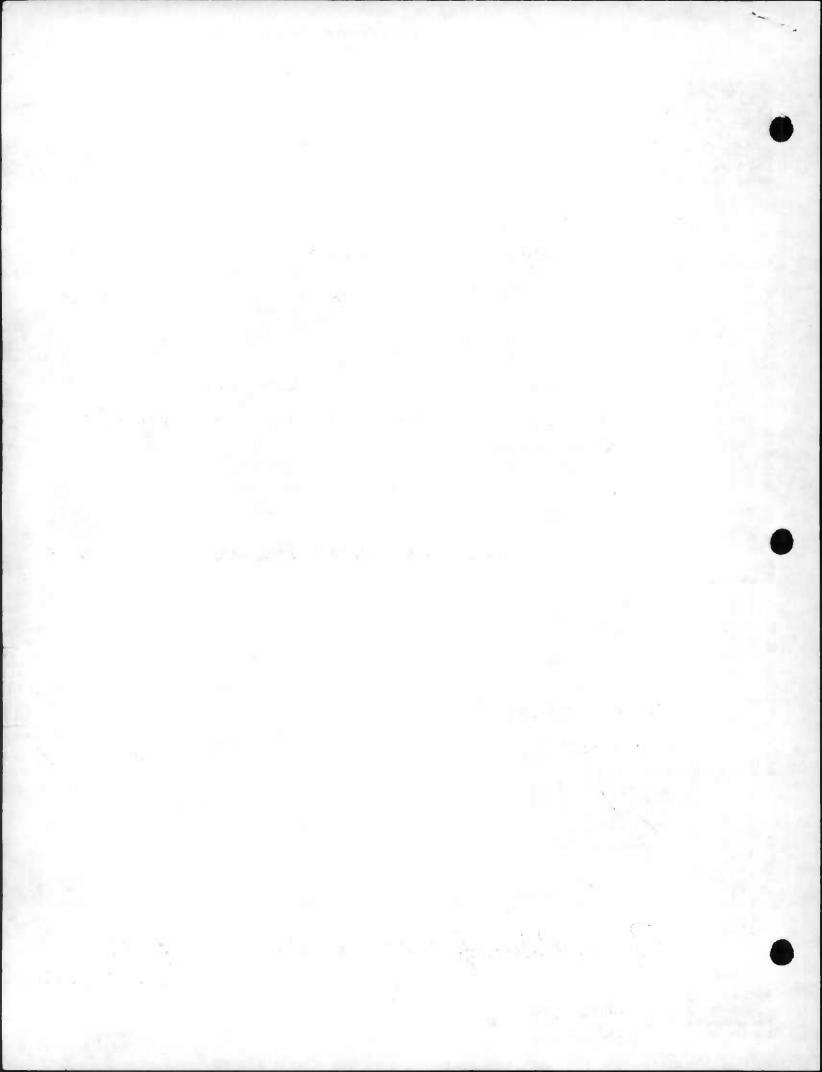
24b. Were autopsy findings eveileble prior to

completion of cause of death?

1 Yes 2 No

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State of Maryland / Department of Health and Mental Hygiene

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		t's Nama (First, Mic	ddia, Last)			
	ician dical	LUTHER	PERRY	ADAMS,	JR.	
		Vama (If not institut	tion, giva straat and i	numbar)		4b. City, Town, or Lo

2. Data of Death 3. Tima of Death

APRIL 18, 1998 1326 PM ocation of Deeth 4c. County of Death MERCY HOSPITAL E.R. BALTIMORE N/A 6. Sex 14D/M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Data of Birth OCT. 29 1951 9. Birthplace (State or Foreign VIRGINIA 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Days 46 Yrs. 217-54-3262 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XXYes 2 □ No MARYLAND BALTIMORE CITY N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country?

1613 NORTHGATE ROAD 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas:

21218 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.)

 Race - Amaricen Indian, Bleck, Whita, etc. Specify: BLACK

U.S.A.

15. Decedent's Education (Spacify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade

 Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) SANITATION WORKER

1 ☐ Yas 2 ☑ No Spacity:

CITY OF BALTIMORE

16b. Kind of Businass/Industry

17. Fathar's Nama (First, Middla, Last)

1 Navar Marriad 2 Married

3 ☐ Widowad 4 ☐ Divorced

LUTHER P. ADAMS, SR. 19e. Informent's Name/Raletionship (Type, Print)

CATHERINE ADAMS 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

18. Mothar's Nama (First, Middla, Maidan Sumama)

Catherine Adams/Mother 20a. Method of Disposition

XXBuriai 2 □ Cramation 3 □ Removel from Stata

20b. Plece of Disposition (Nama of cematary, cramatory or other place) ARBUTUS MEMORIAL PARK

1613 Northgate Road, Baltimore, Maryland 21218 20c. Location - City or Town, Stata Date

4-25 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility WILLIAM C. 21. Signatura of Furniral Sarvice Licens BROWN COMMUNITY F/H

23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1206 W. NORTH AVENUE Approximata Interval Between Onsat and Daath

Immediete Ceusa (Final disaase or condition rasulting in daath)

ALCOHOL AND NARCOTIC INTOXICATION

Dua to (or as a consaguanca of):

Sequentially list conditions, if any, laading to immediata ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last

Dua t	o (or	es a	consequance of):

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy parformed?

24b. Were eutopsy findings evellable prior to complation of ceuse of deeth?

Ves 2□ No 26. Plece of Death (Check only one)

1 Yas 2 No

examinar? 1 ∑Xx as 2□ No	Hospital: 1 ☐ Inpatiant 2)	Ö €R/Outpatient	3□ DOA	Othar: 4 Nursin	ng Homa	5 Rasidance	6 Othar (
7. Manner of Deeth	28a. Date of Injury	28b. Tima of	28c. In	jury at	28d	Dascribe how inj	ury occurred

5 Pending invastigation 1 Natural 2 Accident

6 X Could not be detarmined

25. Was case refarred to medical

(Month, Day Year) Unknown 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Injury Work? 1 🗌 Yas Unknown

2 X No

Unknown 28f. Location (Street and Number or Rurel Route Numbar, City or Town, Stata)

Unknown

29a. Cartifier (Check only one)

3 Suicida

4 - Homicide

1 Certifying Physician: To the best of my knowladga, daath occurred at the time, data end place, and dua to the causa(s) and mennar as stated.

XIM Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number O.C.M.E

29d. Date signed (Month, Day, Year) APRIL 19, 1998

(Specify)

30. Name and eddress of person who completed cause of daeth (Itam 23a) (Type, Print)

Unknown

Strphen 31. Data tilad (Month, Day, Yaar)
APR 23 adentz, mp 111 Penn Street, Baltimore, Maryland 21201 R

State Registrar 32. Register ulia Davidson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

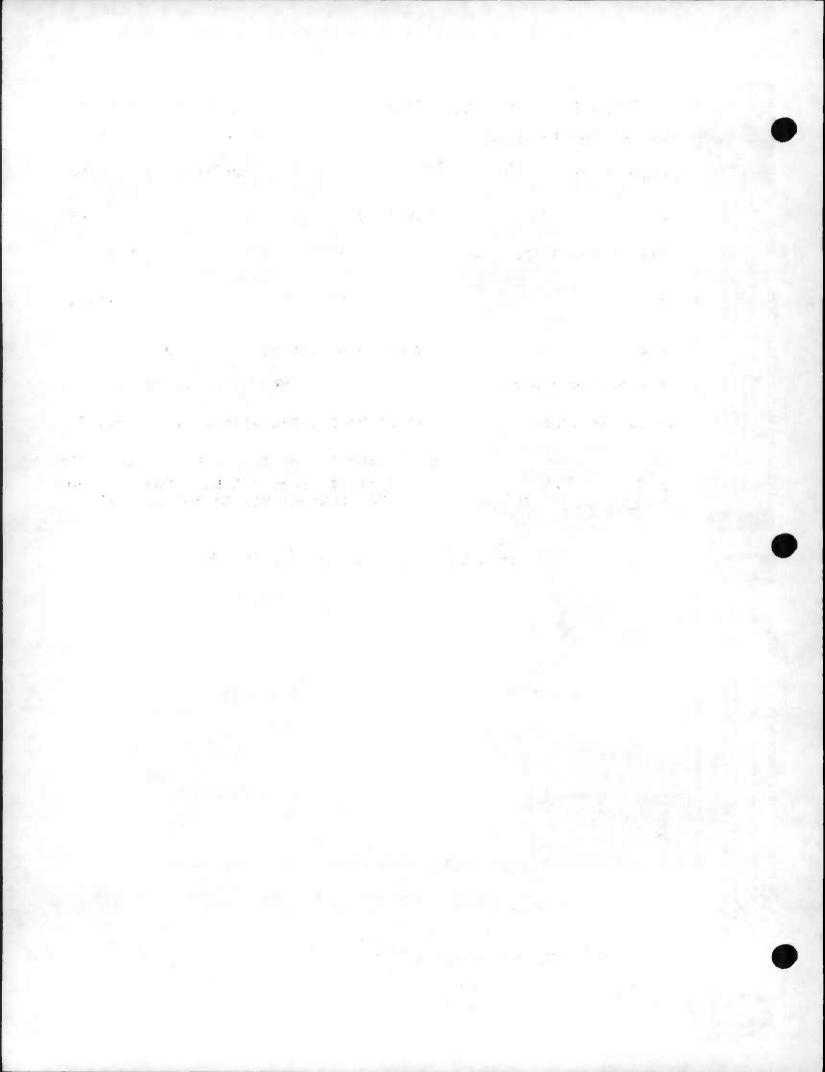
State of Maryland / Department of Health and Mental Hygiene 8

	Certificate of Death	Reg. No.	
		Date of Deeth Months at a Deva 4 Ve	3. Time of Deeth
Physician /Medical		MARIL 24, 1	1:45 PM
Examiner	4h City Town or Locat	on of Deeth 4c. County of E	altimore
Funeral		Date of Birth (Month, Dey, Year)	Birthplece (State or Foreign Country)
Director	213-74-6525 1 M 2XF 89 Yrs. Months Days Hours Min. N	akch 23 1909 M	laryland
M M	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Marylar a or 28a+f show Libe notified at	Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code	10g. Citizen of Whe	1 ☐ Yes 2 No
23 or unit be con	409 Virginia Ave. 21286	USA	(
0 ther death v r home 23s oliner must	11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Free Specify Cuban, Mexican, Puerto Ric		American Indien, Vhite, etc.
20 1 1 2	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:	Specify: V	Uhite
15-002 172 hours "natural", adical Exu	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Busine	ess/industry
1 21215-0 ed within 72 ho yogiene. wer then "neturn it, the Medical.!	(Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Elementary/Secondary (0-12) College (1-4or 5+)	hama	
C Hyge		irst, Middle, Meiden Surneme)	
and dise	1 1 1 2 1 1 1	Dahparis	V:
Maryland 212 d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the M	19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rura) R	oute Number, City or Town, Sta	te, Zip Code)
一 五年25	Thorosa Caro 1706 Groon Sorino Dr.	Lutherville M	d 21093
E 71 44 7	20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place)	Date 25 20c. Location - City	or Town, State
Baltimor semit. Pages Separment of I mportant: if its my injury or of abos.	4 Donetion 5 Other (Specify)	198 Nundal	K. Maryland
Balti Balti Departi mports any inju	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility	no Funeral (hapel
Z W ADSEA	ARISTA J. Wells 2325 VORK Rd TIME	mum Maryla	and 21093
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one ceuse on each line.	espiratory arrest,	Approximete Interval Between
Physician /Medical	disease or condition	то	MONTHS
Examiner	resulting in deeth) Due to (or es a consequence of): CORONARY ARTERY DISEASE		
ds, P.O. Box 68760, lires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit dby Physician Medical Examiner	Sequentially list conditions. Due to (or es e consequenca of):		
x 68760, entificate be executed ling physician and e as the burat-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury c. CHRONIC RENAL FAILURE		MONTHS
68760, ifficate be ex g physician as the burial	that initiated events pue to (or es e consequence of): resulting in deeth) Last		
oentific certific ding	d		
Boy Beath of attend of for us	Dot II Other significant conditions contribution to doubt but not requiling in the underlying source gives in Dot I	23b. Did tobecco use contril	nute to the cause of death?
P.O. Bo at the death c d by the attend etached for us	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		Probably 4 Unknown
S, F as that so that be det			
Division of Vital Records, or Attanding Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed by		24a. Wes en autopsy performed?	4b. Were eutopsy findings available prior to
The law requirate has been spage 2 should	<u> </u>		completion of cause of deeth?
Vital Relations The law certificate has rector, page 2		1 ☐ Yes 2XX No	1 ☐ Yes 2 XNo
Vita clan: entific ector,	25. Wes case referred to medical examiner?	Check only one)	
Physic this c al direction. To	in an inpatient 2 2 2 10 outpetient 5 2 5 7 1 and 3 mg from 6	5 ☐ Residence 8 ☐ Other (I. Describe how injury occurred	Specify)
After funer	27. Menner of Death 1. Naturel 5 □ Pending (Month, Day Year) 28c. Date of Injury 28b. Time of Injury Work? 28c. Injury et Work? 1 □ Yes 2 □ No	. Describe now injury occurred	
Attendant death of the sy the	2 Accident Investigation 3 Suicide 6 Could not be determined could not be determined not could not be determined not could not be determined not could not be determined not could not	Location (Street and Number of	or Rural Route Number,
Division of standing P is after dealin and in the funer lied in by the funer Certification:	4 ☐ Homicide building, efc. (Specify)	City or Town, Stete)	
Division of Vital Records, P.O. Bo To the Hospital or Attanding Physician: The law requires that the death or within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for us Medical Certification: To Be Completed by Physician			
omple omple	29b. Signeture and title of certifier 29c. License number	29d. Dete signed (A	fonth, Day, Year)
- > - 0	Matinided D. de Len, m.D. D 19508	21st an	if 1998
90	CO Name and address of account of the County (Name CO) (Table Date)		
X	NATIVIDAD_D. DELEON, 7620 YORK ROAD, TOWSON,	MARYLAND 21	204
State Registrar	31. Dete filed (Month, Dey, Year) APR 23 1998 32. Registre & Signature April 23 1998		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Deeth **Physician** 15 21 LAIND 998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Keswick Nursing Home Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1 M 2 AF 216-24-7349 Usuel Residence of Decedent 81 Yrs Aug. 28, 1916 **Director** VA with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 3□Xyes 2□No MD n/a Baltimore Director 10e. Street and Number 10f Zip Code 10g. Citizan of Whet Country? 1618 Gwynns Falls Pkwy 21217 USA permit. Pages 1 end 2 should be filed within 72 hours efter death v Department of Health and Mantal Hygiena. important: if Item 27 is marked other than "natural", or Items 23a any injury or other traumatic evant, the Medical Evant ner mant page. Funerai 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Bleck, White, etc. 11. Marital Status Yes 2 No If Yas, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXXo Specify: Specify: þ 3 Nidowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Nursing Assistant Health 11th 18. Mother's Neme (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Jettie Booker Woods Margaret T. Tolson 19e. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Judson Wood/son 12 Kiska Ct. Randallstown, MD 21133 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Burlel 2 Cremetion 3 Removel trom State 4 Donetlon 5 Other (Specify) 1st Baptist Church Cem. 4/26 Healthsville, VA 22. Name and Address of Fecility James A. Morton & Sons Funeral Home 21. Signature of Funeral Servica Licenses 1701 LAurens St. BAlto, 23e. Pert1 There the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart tailure. List only one cause on each line. Approximete Intarvel Between Onset end Death **Physician** /Medicai Immediete Ceuse (Finel disaese or condition resulting in deeth) Examiner Due to (or es e consequence ot): Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaase or injury Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical that initieted events resulting in deeth) Lest Dua to (or as a consequanca of): as t 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ should t 24e. Wes en eutopsy performed? 24b. Were autopsy tindings eveilable prior to Completed completion of cause of death? certificate has b lirector, pege 2 s 1 Yes 2 No 1 Yes 2 No Physician: 25. Wes case reterred to medical exeminer? Be 26. Piece ot Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 20€No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: Division Bulgu 1/23 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Attac 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted. 2 Medical Examinar: On the tasis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner steted. (Check only 29b. Signature # 29d. Date signed (Month, Day, Year) 30 Mame and eddress of person who completed cause of death (Item 23e) (Type Print) 8 200 W 40 STREET BACTO enh 31. Days tiled (Month, Day, Year) State APR 23

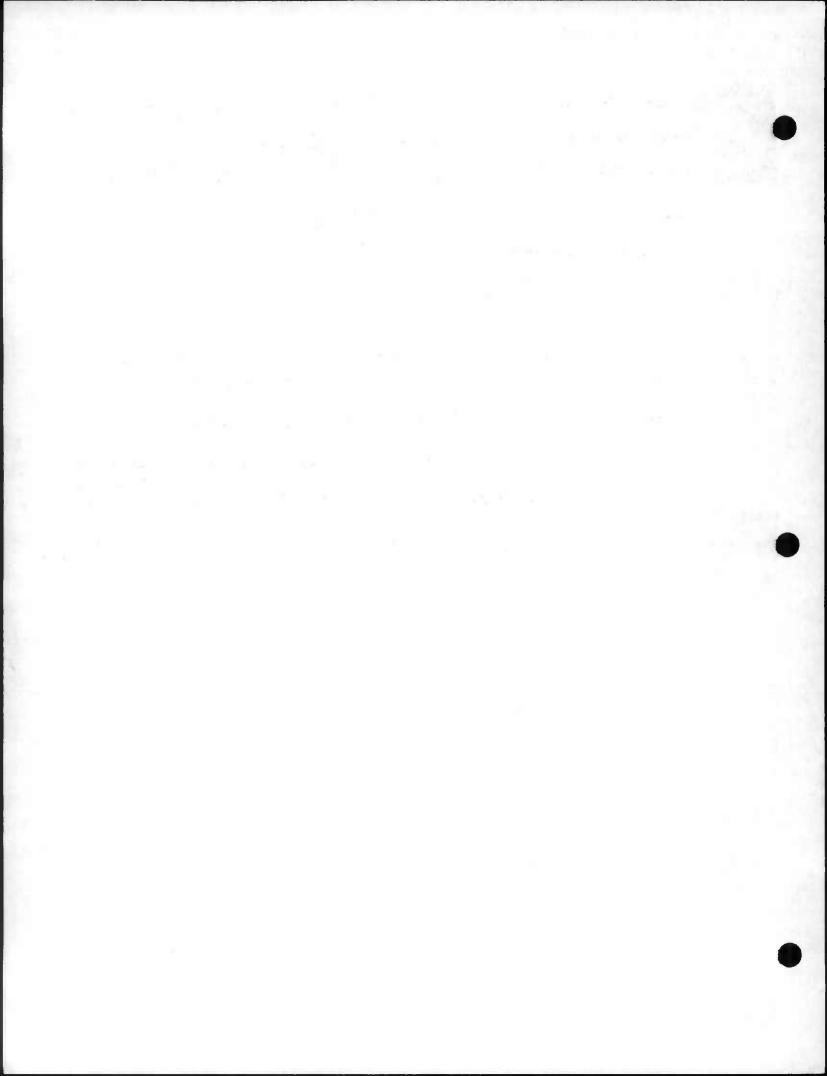
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					,	Certifica	ate of	Death		Reg. No.		
	Physic	ian	1. Decedent's Neme (First, Mide Ruth J. Braxto						2. Dete of De Month	eth Day	Yeer	3. Time of Deeth
J	/Medi	cai			a .			4. Oh. T		20, 199		10:20a.m.
7	Examii	ner	4e. Fecility Neme (If not instituti Manor Care Hea]	lth Services	/Roland			Baltin	Location of Death	NIA	of Deeth	
	Funeral Director		5. Sociel Security Numbar 218–05–7383A	6. Sex 7. A	ge (In yrs. lest bil	Yrs. If Unit Month	der 1 Year ns Deys	If Undar 24 Hrs Hours Min	(Month, De	h, Yeer) 6, 1911		eca (Stete or Foreign ry)
	and w		Usuel Residence of Decedent 10a. State 10b. Count	у	10c. City, Tow	n or Location				•		d. Inside City Limits
	e Mary	ctor	Md. n/	[/] a		Balti	more					170¥as 2□No
	th with the	Funeral Director	10e. Street end Number 529 E. Coldspri	ing Lane			Zip Code 21212			10g. Citizen of V USA	Vhet Count	ry?
020	72 hours after death with the Maryland natural; or Nems 23s or 28s-f show neal Examinal must be notified at	þ	11. Maritai Stetus 1 Nevar Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	KNO 3	_	cedent of I pecify Cub	lispenic Origin? (: en, Mexican, Pual Specify:	Spacify Yas or No do Rican, atc.)		Race - Amarican Indien, Black, Whita, atc.	
5-0	72 hours "natural",	eted	15. Decade (Specify only high	int's Education est grede completed)	16e	Decadent's U	sual Occup work done	eation during most of we	orkina	16b. Kind of B	usiness/Ind	ustry
21215-0020	within ene. than	Completed	Elementery/Secondery (0-12)					during most of wo		Colf D		
Maryland 2	s 1 and 2 should be filed within 72 hour I Health, and Mental Hygiene. Item 27 is marked other than "natural other traumatic avent, are Medical E.	To Be Co	17. Fether's Neme (First, Middle Edward Sheppard			auticia	111		me (First, Middle, Hamilton			3 0
	and 2 should I saith and Meni n 27 is marked or traumatic		19a. Informent's Neme/Relation Barbara McFadde	eship (Type, Print) daug en	ghter 5				ne Balti			
Baltimore,	Page nent o ant: If ury or		20e. Method of Disposition 1		cameta	f Disposition (f ry, cremetory of S Memor	or other ple	*	April 24	Baltimo		
Bal	permit. Pa Departmen Important: sny injury		21. Signatura of Funeral Service **Review Territorian Control of Funeral Service Control of Funeral S	E. Nutte	1				utter Fu PKWY Ba		•	
			23a. Pert1. Enter tha disaase, of shock, or heart failure. Lis	or complications that cause at only one cause on each	d the death. Do line.	not enter the m	ode of dyli	ng, such es cardia	c or raspiratory e	ra <i>s</i> t,		Approximete Intervel Between Onset and Deeth
	Physician /Medical		Immediate Cause (Finel disease or condition	Ren	010. Fa		~ O .				(o wontz
	Examiner	_	resulting in deeth)	. / 4	Due to (or es e	consaquence	of):					.1
-577	uted d ensit	Examiner	Convention list conditions	6. HYJ	Due to (or es e	Sim	<u> </u>				+1	ears
68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the bunal-trensit	Medical Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	C	Due to (or es e							J
Box 6	n certific anding p use as	in/Me		d						-		
	s death	Physician/	Pert II. Other significant condit	lons contributing to death	but not resulting l	n the underlying	g cause giv	en In Pert i.	23b. Did	obacco use co	ntribute to	the cause of deeth?
P.O.	es that the death cer igned by the ettendin be deteched for use	by Phy	Ost	eoguthro	-				10	Yes 2□No	3 Prob	ably 4 Unknown
Wision of Vital Records,	aw requires is been sig 2 should b	Completed b								en eutopsy rmed?	ava	re eutopsy findings ileble prior to aplation of cause eeth?
E R		Com							10	res 20 No	1 🗆	Yes 20 No
Vita	Physician: The I ribis certificate he ral director, page	Be	25. Wes case referred to medical examiner?	Hospital:			0"		eth (Check only o	ne)		
o	Phys r this eral dii	: To	1 ☐ Yes 2 ☐ No 27. Menger of Death	28e. Dete of Inj (Month, De		tpetient 3□	DOA Oth	4 Nursing	Home 5 Rasid	lenca 6 Oth		1
Plon	ath. After he fune	ation	E LI MODICOM	tigetion	ey Year)	njury M		k? Yes 2 □ No				
Divis	To the Hospital of Airenaring Phi within 24 hours alter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could determ	mined 286. Pleca of In	jury - At home, fa tc. (Specify)	rm, street, fact	ory, offica		28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rural	Route Number,
Constilla	Hospi 124 hou Funer letely fill	edical	29a. Certifler (Check only one) 1 Certifyi 2 Medica	ng Phyelclan: To the best i Examiner: On the basis of end menner s	of examinetion an	, death occurre d/or Investigati	ed et the tir on, In my o	me, dete end plec pinion, deeth occ	e, end due to the urred at the time,	ceuse(s) end me date and piaca,	enner es ste end due to	ited. the ceuse(s)
	withir To th	ž	29b. Signature and title of certific	er ()	94	-	29c. Licens	e number		29d. Dale signe	Month, D	ley, Year)
			Shelder	1 Mage	un 4	111	10 5	-377		4/22	178	
	4		Sheldo	N GO do	deeth (Item 23e) C C V	(Type, Print)	7111	N40°	Street	Bolt	ohus	11215
	Sta Registr		31. Deta filed (Month, Day, Yeer APR 23 19	38	Signeture	indell2		<u> </u>	The state of the s			

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State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey APRIL 21 Physician 10:25am 1998 RUTH G. BRADLEY /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner MASONIC HOME OF MARYLAND COCKEYSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociei Security Number 9. Birthplece (State or Foreign Country)
MARYLAND 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** 1 M 2 19/1 90 Yrs. 01-01-1908 078-12-9843 **Director** Usual Residence of Decedent the Manylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2 PKNo Director BALTIMORE COCKEYSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 21030 USA 300 INTERNATIONAL CIRCLE Funeral daath r than "natural", or items the Medical Examiner or Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after terment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural; or ite injury or other traumatic event, the Medical Esamine. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 MNo Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 2YRS (1-4or 5+) EDUCATION TEACHER 17. Fether's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Melden Sumeme) ELEANOR DAWES WILLIAM P. BRADLEY 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) ROLAND GRAY JR. (ATTORNEY) 1 CENTER PLAZA BOSTON, MA. 02108. Baltimore, 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or GREEN MOUNT CREMATORY04/22/98 BALTO., MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. fellia Westill 4905 YORK RD. BALTO., MD. 21212. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final CARCINOMA OF Colon disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner burial-transit certificata be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): physician Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of) SB USB signed by the a Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Consestive Heart Failure by 24b. Were eutopsy findings eveileble prior to 24e. Was en eutopsy Completed peed completion of cause of deeth? page 2 s 1 Yes 2 KNO 1 ☐ Yes 2 ☐ Yo Division of Vital director Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After or Attending 1 Neturei 5 Pending eftar deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completaly (Check only one) To the I within 2 To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier D21464 us 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

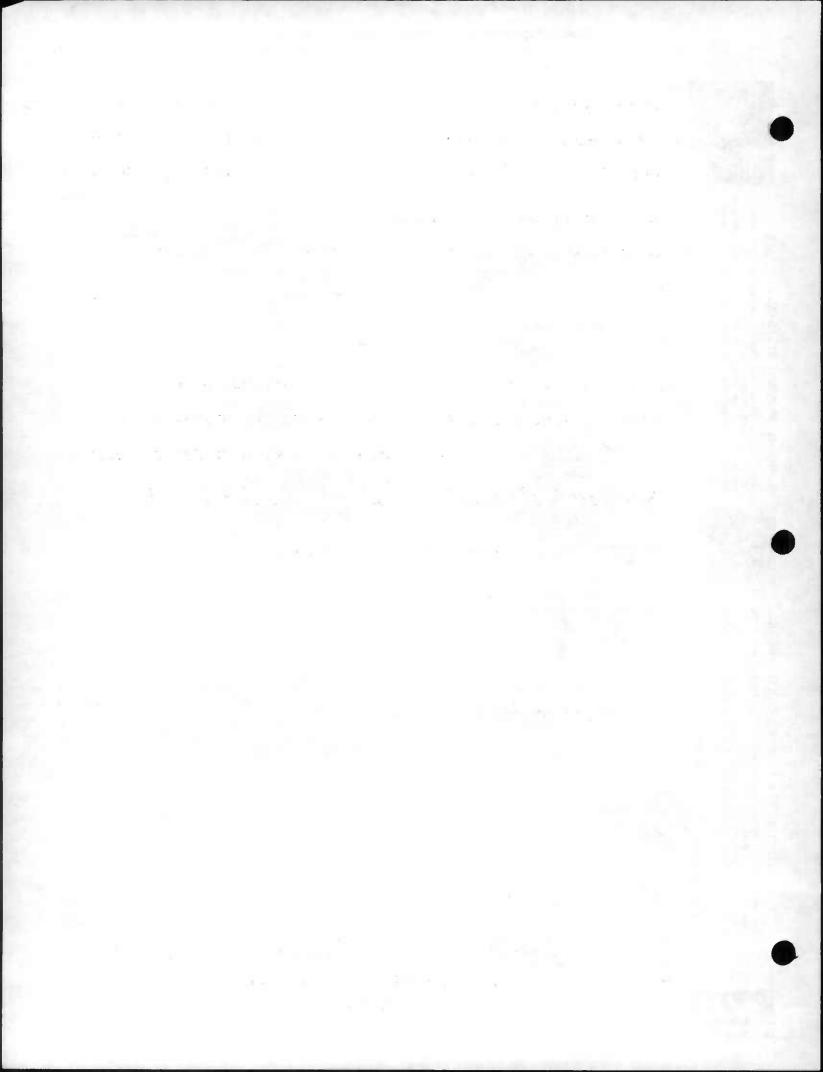
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32. Register Signature don Andrea

ROBERT LIBERTO M.D.

BANK STREET BALTO., MD. 21224.

State Registrar

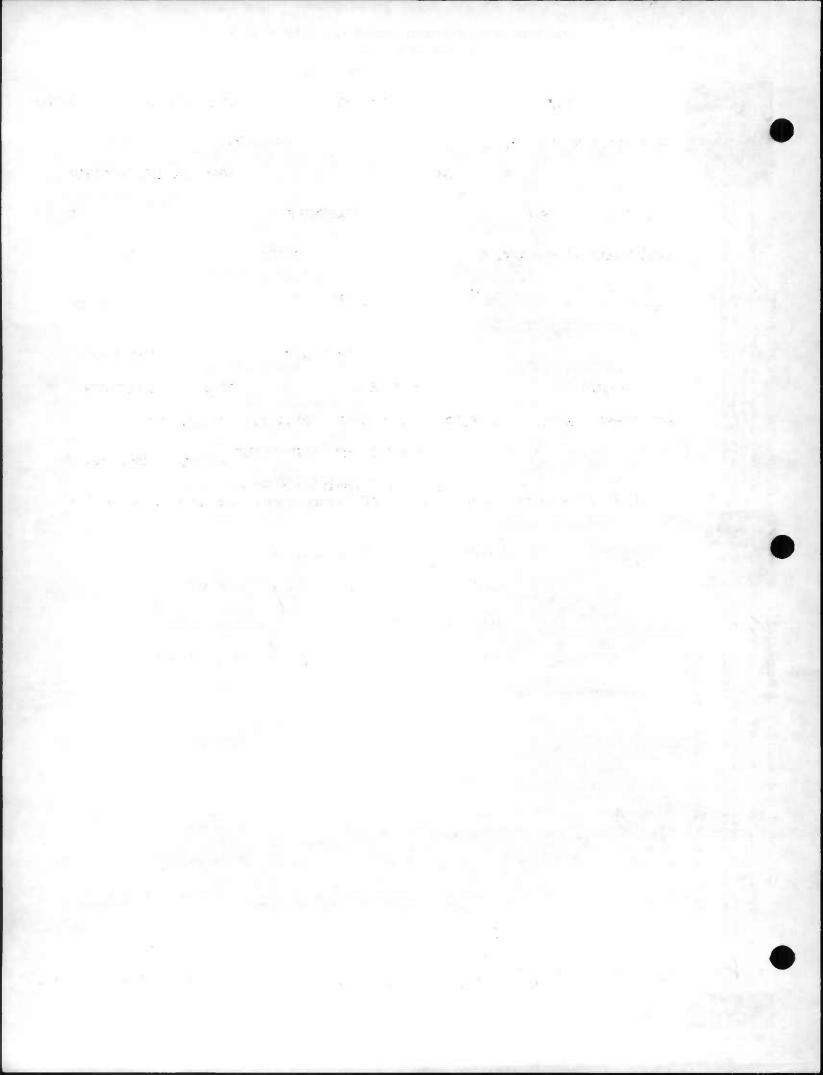


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State of Maryland / Department of Health and Mental Hygiene

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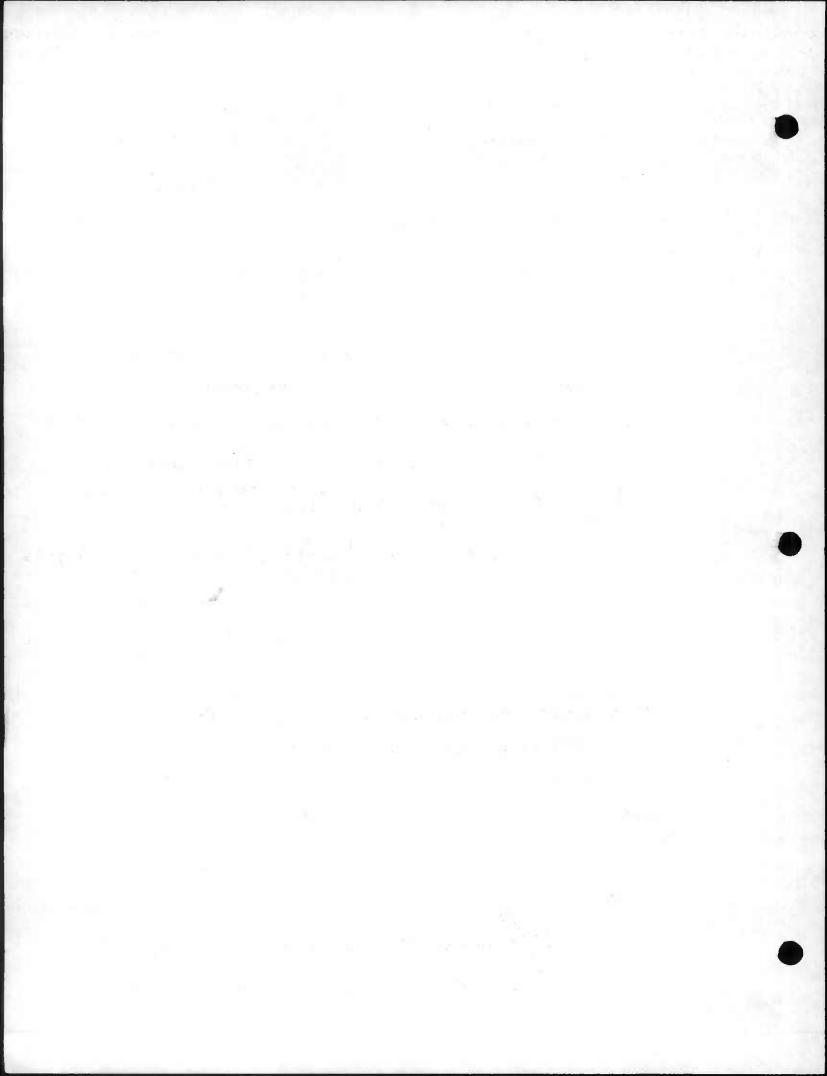
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Saltimore, emit. Pages 1 a pourtient of Hearmontont if Naminy or other more interested.	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Spec		20b. Placa of Disp cemetery, cre MTKR	osition (Nama of Imatory of other of KODESH	BETH I	SRAEL 4-2	20c. Location - 2–98 BA	City or Tow	
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	Funerai Director		5. Sociel Security 1 244-26	6. Sex 1 □ M 2 🖾 F	Sex 7. Aga (In yrs. lest birthday) If Un				8. Data of Bi (Month, D	rth ey, Year)	h 9. Birthplace (Ste				
	aryland show		Usuei Residence of 10a. Stete	10b. County		10c. City, Town or Location							0d. Inside City Limits		
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	or 28	Director	10e. Street end Nu	mber				10f. Zip Code		10g. Citizan of What			ntry?		
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ē,	s 1 end 2 should be filed f Health end Mental Hyg tem 27 is marked othe other treumatic event,		20a. Method of Dis				20b. Plece of Dis	position (Neme of							
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Ball	permit. Peges 1 end Department of Healt Important: If item 27 any Injury or other 6		21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Dundalk												
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Division	or Atter after des Director In by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inad 286, FIEC	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)						
	To the Hospital or Attending Physician: The is within 24 hours aftar death. To the Funeral Director: After this certificate he completally filled in by the funeral director, page.	edicai C	29a. Certifier (Check only one)	Certifyin 2 Medical	Exeminer: On the k	best of m asis of exe	aminetion end/or	oth occurred et the ti investigetion, in my o	me, dete end piece, opinion, deeth occur	end due to the	ceuse(s) end m	nanner es st	eted. the cause(s)		
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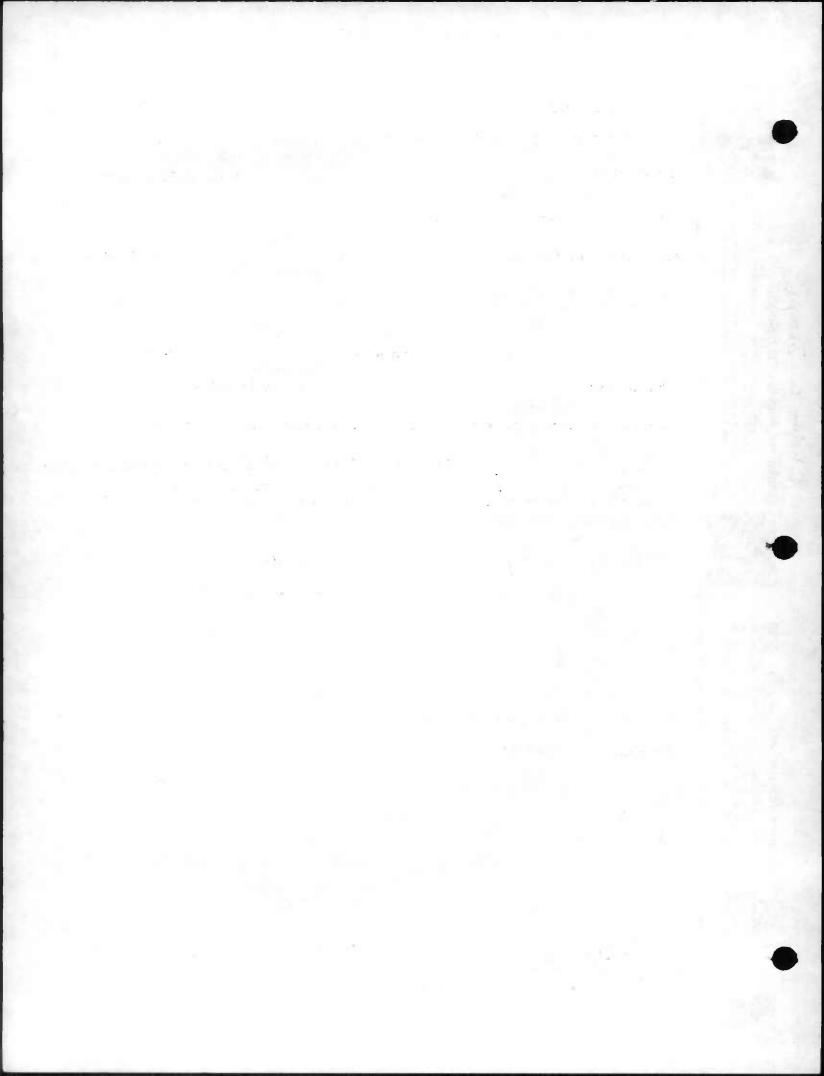
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State of Maryland / Department of Health and Mental Hygiene 3 2837

		Certificate of Death Reg. No.											
/sician	Decedent's Name (First, Middla, Last)								Dete of De Month	th Dey Yaer		3. Time of Death	
an cal	Joseph B. Chrobak							2	051		998	4:30 P.M	
r	4e Facility Neme (If not institution, give street end number) NORTH ARUNDEC HOSPITAL GLEN								m, or Location			County of Death	
	5. Social Security No. 213-07-55		Sex 1⊠M 2□F	7. Age (In	yrs. last birthdey Yrs.	Months	Yaar Deys	If Under 24 Hours	Min.	Dete of Bir (Month, De	th ly, Year) 21,1912		plece (State or Foreign intry) tria
	Usual Residence of				0. 7								
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	Ohio	hio Harrison Cadiz											
Ohio Harrison Cadiz 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Cadiz													
	49235 Foxes Bottom Rd. 43907 11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (5										United		
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	/Spec	15. Decedent's	Education rede complated))		edent's Usuei e kind of work			of working		16b. Kind of I	Business/I	ndustry
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	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d Zee. Plac	a of injury ling, etc. (S	At homa, ferm, s Specify)	treet, fectory,	office		28f.	Location (City or To	Street and Num wn, Stete)	nber or Ru	ral Route Number,
10000	29a. Cartifier (Check only one)	12 Certifying F 2 Medical Ex	aminar: On the b	e best of m besis of exa oner steted	y knowledge, dea minetion end/or i	th occurred el nvestigetion, i	the tir	ne, date end plnion, deeth	pleca, end h occurred e	due to the at the time,	ceuse(s) end n date end place	nanner es , end due	stated. to the cause(s)
1	29b. Signeture	title of certifier				29c.	Licens	a number			29d. Data sign	ed (Month	n, Day, Year)
	> ///	WW)				D	40	525			April	21,	1998
	30. Name erlo addre	ss of person wh	completed cau	se of deeth	(Item 23e) (Type	Λ	ru	wel	ito	سامار	d.		
te ar	31. Date filed (Mont	h, Dey, Year) 2 3 1998	full	Burg	Signature Vont-Admicke	22							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 2838 State of Maryland / Department of Health and Mental Hygiene Item: 5 per F.H. G-759 5/7/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 1998 11:44 AM JOSEPH LOVIS CONNOR APRIL 21 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Y) 7. Aga (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 6. Sex Months Hours Devs 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a Stete 10b County LEYES 2 No BAltiMOE brykno 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2/215 5/02 1151 LDELLA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Defas: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)

FORK Ciff DW VOT 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) winners Elementary/Secondery (0-12) College (1-4or 5+) 10 1 grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) CLAN/ES BAROY 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) proclia At Boltowolf, Med 21215 5/02 USTINE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, Stete 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from State MUUNT Crem stopping 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signefure of Funeral Service Licans MAR 40 REISTUSTUN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batwaen Onsat and Death Immediate Ceuse (Finel Lung cancer disease or condition resulting in death) Due to (or es e consequence of): - esophageal tracheo Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown 24b. Were eutopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? 2 000 1 Yes 2 No 1 Yes 25. Wes cese referred to medicel examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 npatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

/Medical Examiner physician and the burial-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760, 68 use signed by the a certificate has b director, pege 2 s After this funeral

Examiner Physician/Medical þ Completed To Certification:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of health and Mentel byglene. In the firem 22 acr 28 a

Baltimore, Maryland 21215-0020

th and Mentel Hygiene. 7 Is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at

Department o Important: If i any injury or

Physician

Hospital or Attending Physician: 24 hours after death. after death To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th

edical

29a, Certifier

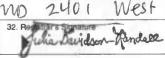
29b. Signature end title of certifiar

31. Dete filed (Month, Day, Year)

State Registrar

oven Mis 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Ellie G. Cohen MMD

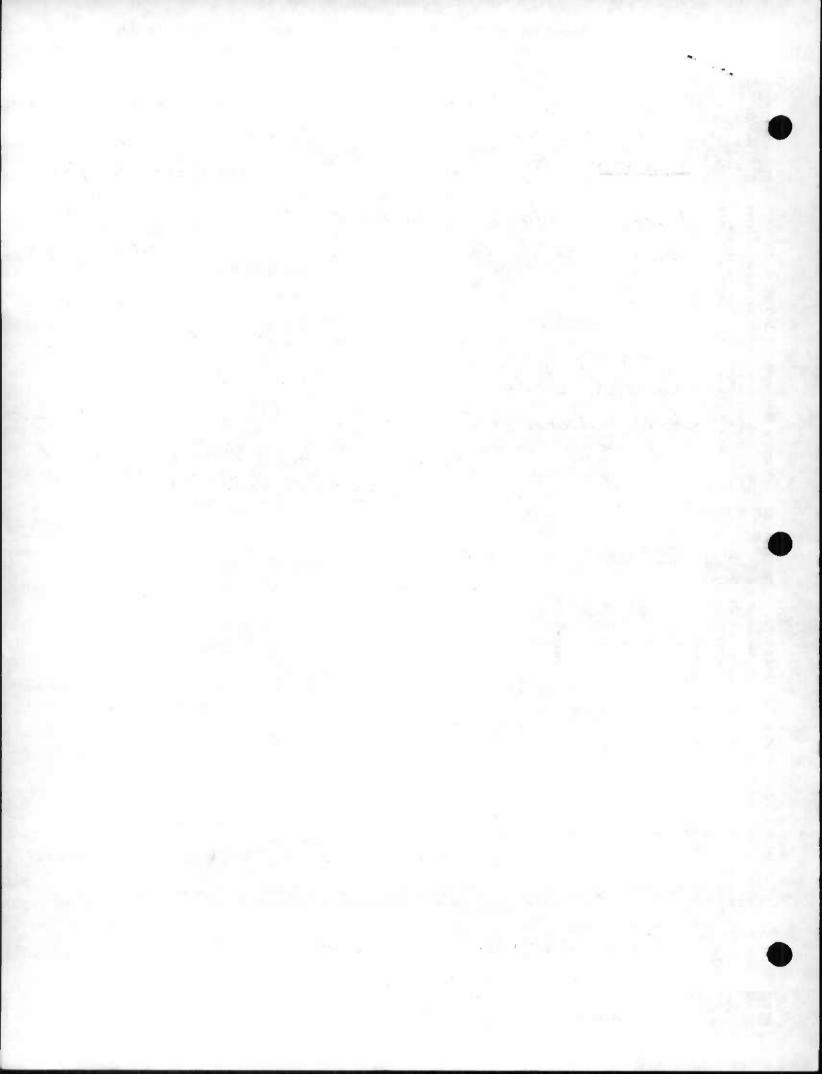
APR 23 1998



1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dafa signed (Month, Dey, Year) 29c. Licansa number AS 2402321-EC9008

April 21,

Beivedere Avenue Baltimore, MD 21215



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

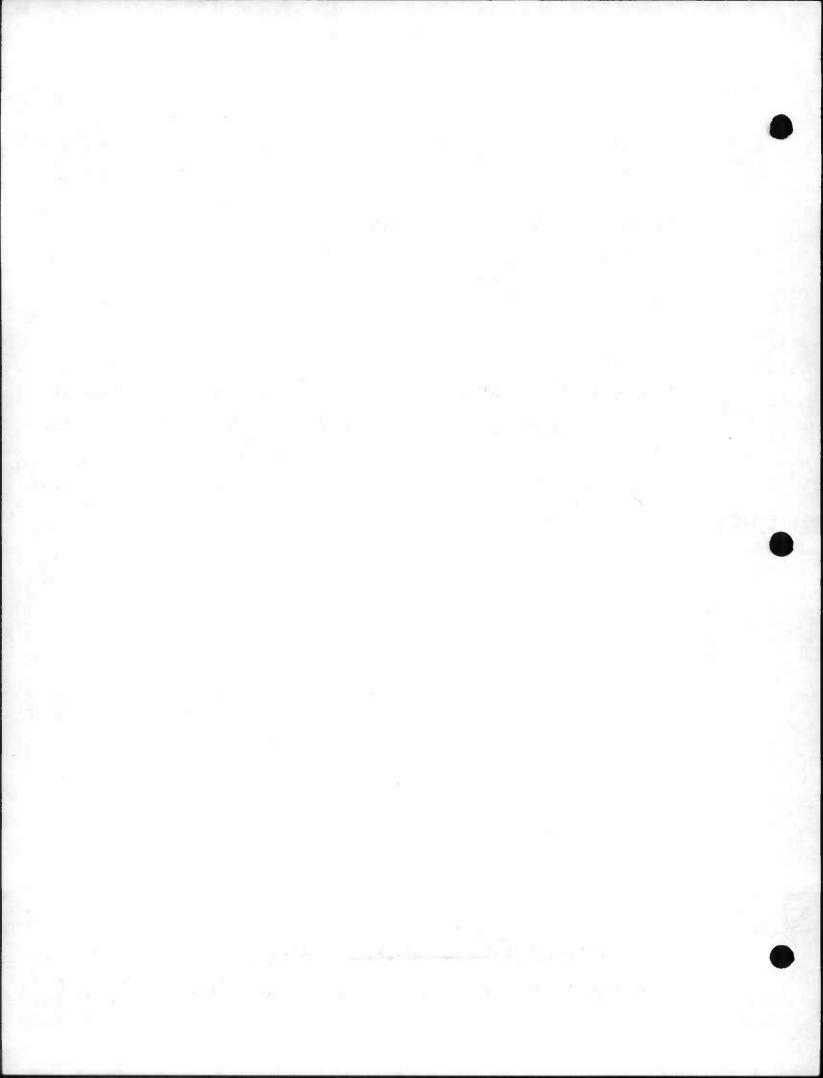
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 4 5m /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, If Undar 1 Yeer Z Aga (In yrs. last birthdey) 5. Social Sacurity Number 6. Sex Birthplace (Steta or Foreign Country). **Funeral** Days 1 X M 2 □ F 212-05-5726 Yrs Director Usual Rasidanca of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Director Maeyland 4 MORG 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 316 Funeral 12. Wes Decedent Evar in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-II Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Yas 2 No If Yes, Give Yeer or Dates: 1 Naver Merried 2 Marriad Baitimore, Maryland 21215-0020 1□ Yas 2⊠No Spacify. Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Spacify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Collage (1-4or 5+) 18. Mother's Neme (First, Middla, Maldan Sumama) 17. Fethar's Nama (First, Middla, Last) 19e. Informant's Name/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 ⊠Buriei 2 ☐ Cramation 3 ☐ Ramoval from Stete any injury or o 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility 21. Signature of Funeral Service Licanees va Part : Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart fallura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final diseesa or condition rasulting in death) COUDE Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, laading to Immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or es a consequance of) Records, P.O. Box 68760, Due to (or es a consequance of) Part #. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown ٥ 24b. Wara autopsy indings aveilable prior to completion of ceuse of daath? Completed 24e. Was an autopsy performed? 1 Yas 2 HO 1 ☐ Yes 2 ☐ No director. 25. Was casa refarred to medicel axaminar? Be 28. Piace of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) ٩ 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Data of injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how Injury occurred : After ! 5 Panding Investigation Natural 1 Yas 2 No after death the f 2 ☐ Accident 6 Could not be datarmined 3 ☐ Suicida 28i. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral I 1 Certifying Phyeician: To the best of my knowledga, daath occurred at the time, dete end place, and due to the causa(s) and mannar as statad.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end menner stated. 29a, Cartifier Medical (Check only one) 29b. Signatura end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 10 30. Neme and addrass of person who completed ceuse of death (Item 23a) (Type, Print) 21001 31. Date Hied (Month, Day, Year)
APR 23 1998 32. Registre s signature

Fuha Davidson State 1998 Registrar

DHMH 16 Rev 6/95

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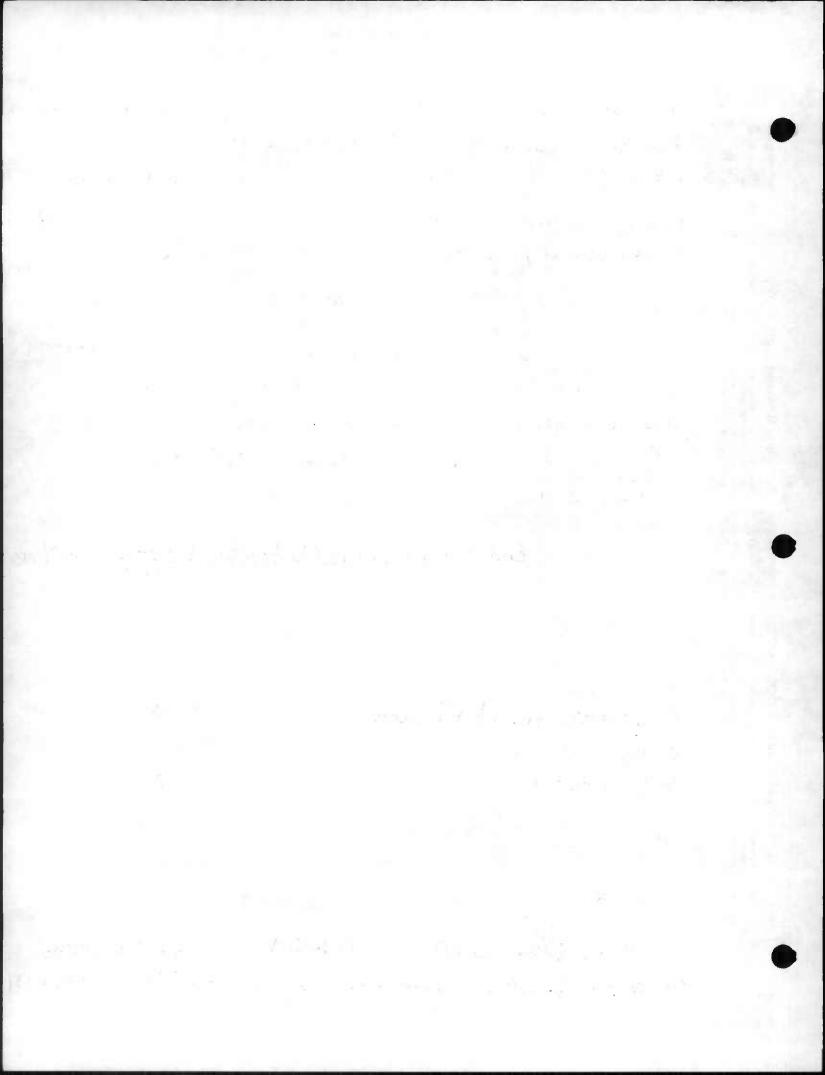


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene | 2840 Certificate of Death Reg. No. 2. Date of Death Month Day Year 3. Time of I

		Certificate of Maryland / Department of 1									
	Physiciar /Medica	1. Decedent's Name (First, Middle, Last) Bernard Oberly Dennig	2. Date of Death Month Day Year ADD 16 1998 10:20 A								
	Examines Funeral Director	48 Facility Name (If not Institution, give street and number) Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year 178 10 1884 178 20 F 87 Yrs.	ROSEDATE BOLTIMORE If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) May 18,1910 The Country of Death Boutimore 9. Birthplaca (State or Foreign Country) Nay 18,1910 Indiana								
21215-0020	the Maryland. 28a-f show notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Abingdon	10d. Inside City Limits 1 ☐ Yes 2 No								
	thar death with the Ma r thams 23a or 25a-f a niner must be notified	10e. Street and Number 506 Ramblewood Drve Apt. 401 210	10g. Citizen of What Country? U.S. A.								
			ilispanic Origin? (Specify Yas or No- an, Maxicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. Specify: Specify: White, etc.								
	be filed within 72 hours tal Hygiene. d other than "natural", a event, the Medical Exa-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) College (1-4or 5+)	Mailing								
Maryland	Mental Hy mrked othe wife event,	17. Fathar's Name (First, Middle, Last) Charles Dennig	18. Mothar's Name (First, Middle, Maiden Sumame) Alice unknown								
	and 2 sh south and m 27 is re her traum	David Billingsley 601 Charwood									
Baltimore,	Pages 1 ment of H ant: If Ne jury or of	20a. Method of Disposition 1 Remarks 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 6 and length of the place of Disposition (Name of cemetery, cremetory or other place)	1146 1 1								
Ball	Depart Import any in	21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility Evans (hapel of Memories 8800 flar for Red Baltimore, MD 21234									
	Physician /Medical Examiner	23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not anter the mode of dyin shock, or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) a. End Stage Chronic Due to (or as a consequence of):	Approximate totervel Between Onset and Death Chostructive Pulmormy 30 Year								
P.O. Box 68760,	ing physician and se es the bunial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
	The law requires thet the death certate hes been signed by the attending page 2 should be deteched for use	Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause give Congestive Heart Failure	ren in Part I. 23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown								
Records,	law requires thet es been signed to 2 should be detected by D	Emphysema	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?								
Vital	cartific	25. Wes case referred to medical examiner? Hospital: Manual Control of the contr	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)								
Division of	Aftar this funeral di	27. Manner of Death 28. Dete of Injury 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	4 Nursing Home 5 Hesidence 8 Dotner (Specify)								
D	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the Mardinal Cartifical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the tire of the basis of examination and/or investigation, in my of and manner stated.	me, date and place, and due to the ceuse(s) and menner as stated. pinion, death occurred at the time, date and place, and dua to tha cause(s)								
	To To To To To To To To To To To To To T	29b. Signatura and title of certifier 29c. Licens	a number 29d. Date signed (Month, Day, Year)								

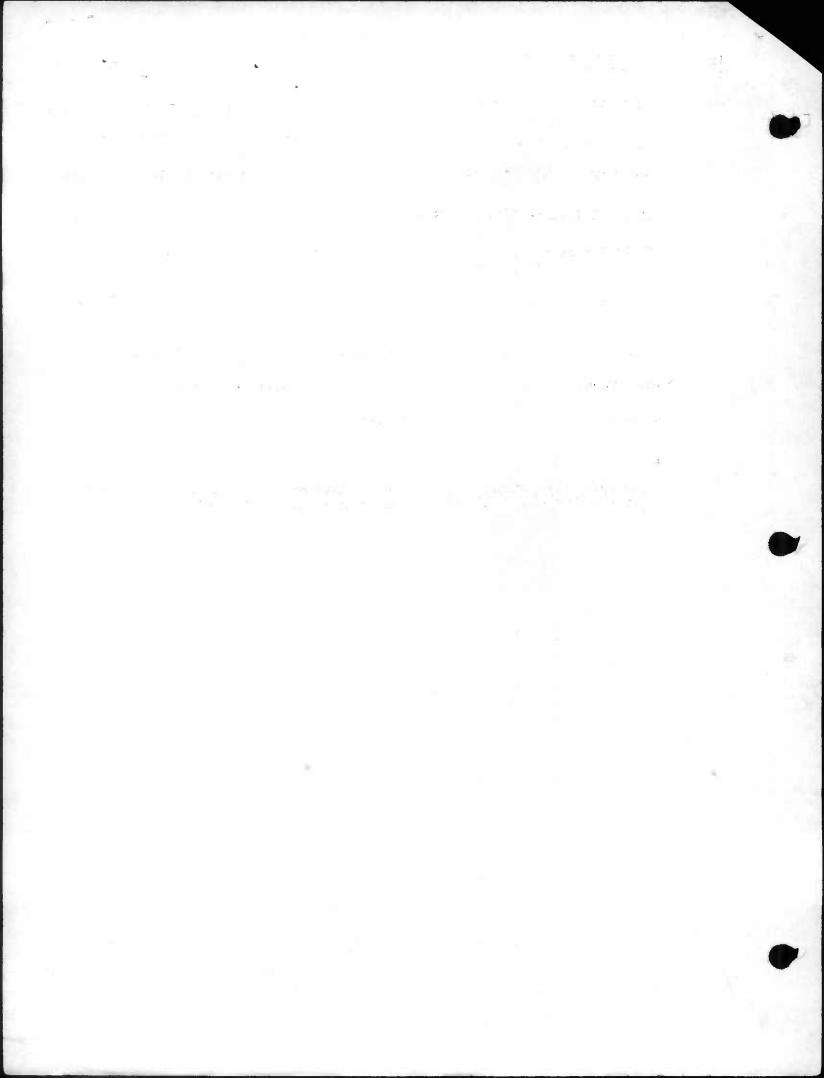
State Registrar

DHMH 16 Rev 6/95



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	Physici /Medi		1. Decedent's Name (First, Middle, Last)	2. Dete of De Month	Th Day 1998 9:40 11							
	Exami		4a. Fecility Neme (If not institution, give stre Liberty Medical Cer				4b. City, Town, or Baltimo	Location of Dea				
	Funeral Director		5. Social Security Number 219-22-3093 Usual Residence of Decedent		If Under 24 Hrs. B. Date of Birth (Month, Day, Year) April 14,1926			9. Birthplace (State or Foreign Country) Maryland				
	Maryland H ehow	tor	10a. State 10b. County Maryland Baltimore		ity, Town or Local Saltimor					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	ath with the Marylan 23a or 28a-f show	ral Director	10e. Street end Number 2503 Violet Avenue			10f. Zip Code 2121	5	:	10g. Citizen of U.S.A.	What Count	ry?	
020	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Exemple must be notified	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Detes:	d Forces? de 2 l⊠No 3, Give 1 □ Yes 2 l∰ No Specify:			Specify Yes or Noto Rican, etc.)		ce - America ck, White, e y: Bla	etc.	
Maryland 21215-0020	d within 72 ho jiene. r than "natur on Medical	Completed	15. Decedent's Educeti (Specify only highest grade of Elementary/Secondary (0-12)	on ompleted) College (1-4or 5+)	ent's Usual Occup kind of work done OO NOT use retired	orking	16b. Kind of Business/Industry Hospital					
and	ould be filed Mentel Hygi arked other atic event, to	To Be C	17. Father's Name (First, Middle, Last) Norman Young					ite John	, Maiden Surnar			
Mary	nd 2 sh alth end 27 le m r traum	Ė	19a. Informant's Name/Relationship <i>(Type,</i> unknown	Print)	19b. Mailin unkn				umber, City or Town, State, Zip Code)			
Baltimore,	60 45 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 🖾 Donation 5 □ Other (Specify)				Date	20c. Location - City or Town, State				
Balt	pemit. Page Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee Ronald S. Wade	U mae	St Ba	Neme and Addre tate Anat altimore	omy Boar	nd 21201		imore	Street	
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (GSTY	(Tire	Lanc	DIS	eases			
	uted	Examiner	- 8-	Congern	re H	east F	aillur	~				
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of Vital Records,	been should	Completed by F						24a. Was	an autopsy ormed?	con	re autopsy findings iiable prior to apletion of cause eath?	
al Re							(9)	10	Yes 2√√√ No		Yes XX No	
r Vit	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medicel examiner? 1 Yes 2 No	ital: 1 ☑ Inpatient 2 ☑	ER/Outpetient	3□ DOA Oth	or.	ath (Check only		ner (Specify		
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D.	vital or Attendurs after death		4 Homicide datamined	8e. Piace of Injury - At I building, etc. (Speci	ify)			City or To	(Street and Numi wn, State)			
	To the Hospital or / within 24 hours aftar To the Funeral Dire completely filled in L	edical	29a. Certifier 1 Certifying Phyafcia (Check only one) 1 Medical Examiner:	n: To the best of my knoon the basis of axaminand manner stated.	owiedga, death ation and/or inv	occurred at the tin estigation, in my o	na, date and place plnion, death occ	e, and dua to tha urred at tha time,	cause(s) and made and piace,	annar as sta and due to	ited. the ceuse(s)	
	With Con	Σ	29b. Signeture and title of certifier 12 - Sho	u s		29c. Licens	e number		29d. Date signe	(Month, D	Day, Year)	
	4		30. Name and addrass of person who compile? ————————————————————————————————————	eted causa of death (Ita	m 23a) (Type, F	Print)	+ WE	Ball	imore	, ma	MILAND	
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2.3 1998	32. Registrar's Sign	ature Rand	late	,			1		



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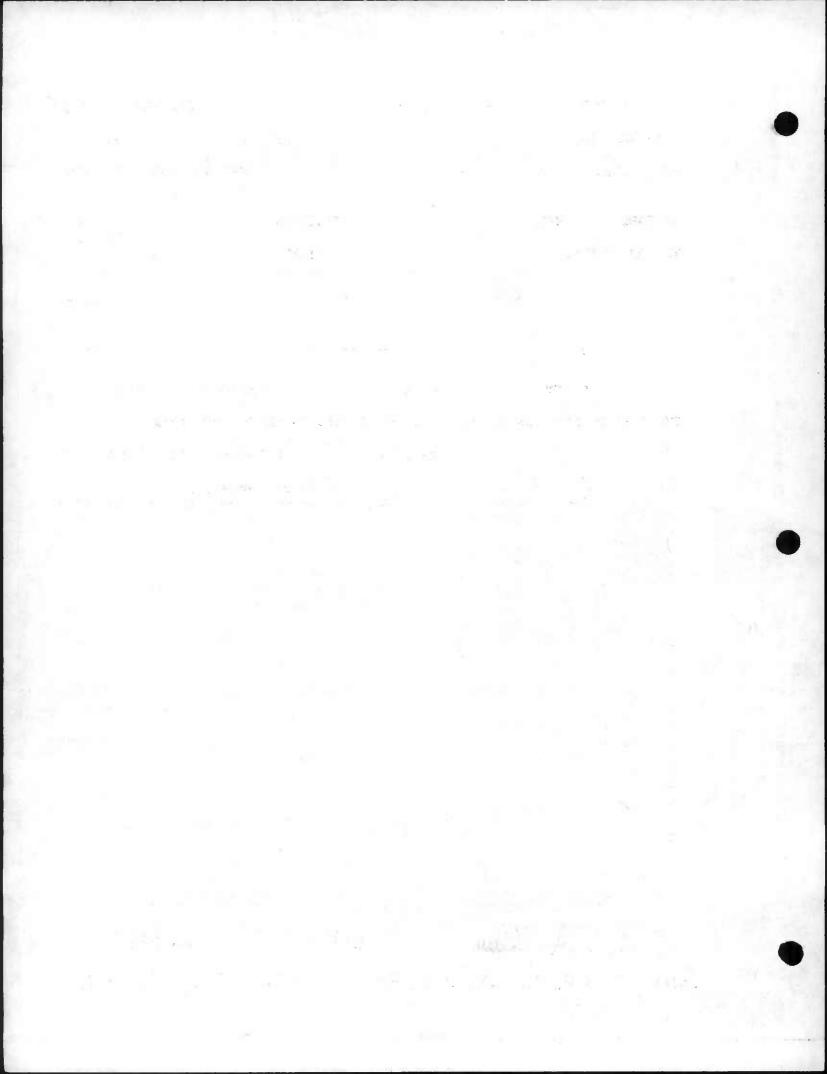
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	Funeral Director		5. Social Security Number 261-84-0352 1 M 2 F 52 Vrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 261-84-0352 1 M 2 F 52 Vrs. 1 Months Days Hours Min. 1 Winder 24 Hrs. 1 Months Days Hours Min. 1 NOV • 19									9. Birthp		tete or Foraign ORK
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Vital	ysician: The is certificate director, pag	Be	25. Was cese referred to medicel examiner?	Lies-Hali					of Death	h (Check only o	ne)		11	
0	this aldi	. To	1 Yes 25000	Hospitel: 1 Inpatier			DOA			me 5 Resid		ner (Specif	A) H	ospice
Division	ding h. After fune	Certification:	1 Netural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury Work? n M 1 ☐ Yes 2 ☐ No					28d. Describe how injury occurred				Absorber	
<u>></u>	5 5 5 G		4 Homicide determined	determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f, Location (5 City or Tox		Der or Hura	ai Modie	rvumber,
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	19		30. Neme and eddress of person who	completed cause of de	eth (Nem 23e) (T	ype, Print)	. ch	moles	St	. Br	Cto. 1	nd a	212	05
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State of Maryland / Department of Health and Mental Hygiene

			11			Certificate	e of	Death	F	leg. No.			
ľ	Physic	ion	1. Decedent's Name (First, Middle, La	st)					2. Dete of Dee	th	Voor	3. Time of Deeth	
J	/Med		STEPHEN	MARK	Di	DAVIS APRIL 21, 1998 ear APRIL 21, 1998 ear 4c. County of Deeth BALTIMORE N/A		0325					
	Exami		4e. Fecility Neme (If not institution, giv MERCY HOSPITAL	e street end number)						4c. County			
	Funeral Director			D	ge (In yrs. lest bir 49	thdey) If Under Yrs. Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day JULY 13	Year) 1948	9. Birth MAR	plece (State or Foreign intro:) YLAND	
	pue M		Usuel Residenca of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits	
	he Maryi 28a-f sho	Director	MARYLAND NA	'A				LTIMORE				1 XYes 2 □ No	
	ath with t	ral Dir	403 WARREN AVE.			10f. Zip		21230		0g. Citizen of V		ntry?	
Maryland 21215-0020	hours after death with the Marylend ural; or items 23e or 28e-f show at Examiner must be notified at	by Funeral	11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 If Yes, Give Yeer or Detes:		13. Wes Deceded If Yes, special 1 Yes 2		Hispenic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	can Indien, , etc. WHITE	
2-0	72 Inat	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16e.	Decedent's Usue	l Occup	petion during most of work	ina	16b. Kind of Bu	usiness/In	dustry	
12	C	id I	Elementery/Secondery (0-12)	College (1-4or	5+)	life. DO NOT use	e retire	od)			D 3 (.78)	CHOD	
9	Hygi ther ther	ပိ	17. Fether's Neme (First, Middle, Last)			PROPE	KTE1	18. Mother's Nam	a /First Middle			SHOP	
au	od la b	To Be	BERNA		DAV	re			SEPHINE				
any	S DEE	-	19e. Informent's Name/Relationship ((Street	end Number or Run			RTIN		
	nd 2 sith e		MRS. MARY DELLA-I	AVIS (WIF				E. BALTIM			, 6666)		
Baltimore,	8 5 5		20e. Method of Disposition 1		20b. Piece of cameter	Disposition (Nem y, cremetory or of SINAI	e of	ce)		20c. Location -			
Balt	permit. Pege Depertment of Important: If eny Injury or pncs.		21. Signature of Funeral Service Licen	Durin			l Le	evinson &			S MILLS, MD		
			23e. Party Enter the disease, or com-	flications that caused	the death. Do r	not enter the mode	of dyl	ng, such es cardiac	or respiretory err	est,	imore, MD 21208 Approximate Intervel Between		
	Physician /Medical		Immediete Cause (Finel disease or condition	Ant	i mar	ا بناید		laute	·			Onset end Deeth	
	Examiner	ner	resulting In deeth)	Arter	Due to (or as a c	consequence of):	<u></u>	Divisi	0.	110011	3	Luca	
,	executed n end naturensi	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or es e	consequence of):		-00-q0 0 0-1-1	2009 10	30,000		, dood	
x 68760,	thet the death certificate be executed by the ettending physician end deteched for use as the burba-trensit	Medical	Cause (Diseese or injury thet initieted events resulting in deeth) Lest	d	Due to (or es e c	onsequence of):							
. Box	deeth c	Physician/	Part II. Other significant conditions or	ontributing to death b	it not resulting in	the underlying ce	ueo ah	en in Port I	23h Did to	hassa una aor	della de de	o the cause of death?	
. P.O.	requires that the deeth seen signed by the etter hould be deteched for r			Annualing to death b	a not resulting in	the underlying ca	iuse giv	on in Port i.	1 🗆 Y		3 □ Pro		
Records,	aw requires thet is been signed I 2 should be det	Completed by							24a. Wes e		av co	ere eutopsy findings relieble prior to empletion of cause deeth?	
		E							1 □ Ye	s MINO		Yes 2□ No	
VItal	iclan: The certificate rector, pag	BeC	25. Wes case referred to medical					26. Plece of Deet		1	11	J 165 2 140	
	Physician: r this certific real director,	To	exeminer?	Hospitel: 1 Inpatie	nt 2 ER/Out	petient 3□ DOA	A Oth	er:	me 5 Reside		er (Specif	か)	
DIVISION OF	Attending Phore of death. Sector: After this by the funeral		27. Menner of Deeth Natural 5 Pending 2 Accident Investigation	28e. Dete of Injur (Month, De)		ime of 28 jury M	Bc. Injur Wor		28d. Describe ho			,	
	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:								28f. Location (Street and Number or Rurel Route Number, City or Town, State)			
	To the Hospital or within 24 hours efter To the Funeral Dir. completely filled in	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece (Check only one) Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece end menner steted.							d piece, end due to the cause(s) end menr th occurred et the time, dete end piece, en		nner es s and due to	teted. the cause(s)	
	To the within To the comp	M	29b. Signature and title of certifier	-elfu		29c.	Licens	e numbar	2!	Hall 9	(Month,	Day, Year)	
	10		30, Neme and address of person who can have S. ANG	SLL, MD	eeth (Item 23e) (Type, Print)	2	L. LUTHS	RVIUS	CM)	21	093	
	Sta Registr	-	31. Dete filed APR 2 3 1998	32. Hogistre	Davidon-	Pandell				4			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** :50 p.M. /Medical 4a. Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** BALTIMORE IOINI NURSING HOME CIT If Undar 1 Yaar If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Sax 10 M 2 F 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 76 217-16-8144 Yrs **Director** 11/06/1921 Maryland Usual Rasidance of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiena. Important: If Itam 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Mentel Examinet must be notified and 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits Director 1 Yas 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Funeral 1725 N. Smallwood St. 21216 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1942 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2√2 No þ Specify: Black 3 ☐Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elementary/Secondary (0-12) Collage (1-4or 5+) 12 Printer Newspaper 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Daniel A Dixon Sr. Lillian Richardson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa Allen/Sister 7203 Seymour Place, Baltimore, Maryland 21207

20b. Place of Disposition (Name of cematary, crematory or other place)

Data

20c. Location - City or Town, Separatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata 04/27/980wings Mills, Md. 4 Donation 5 Othar (Spacify) Garrison Forest 21. Signatura of Funaral Sarvice Ligansee 22. Nama and Addrass of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Md. 21215 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause of makir line. intarval Between Onsat and Death **Physician** /Medicai Immediata Causa (Final one House disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner The lew requires that the daeth certificete be axecuted burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undartying Causa (Disease or injury that initiatad avants rasulting in daath) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 88 ate has been signed by the a page 2 should be detached t Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the causa of death? 3 Probably 4 Onknown 1 Yes 2 No GRIOSCL GOSIS Records. Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? this certificate 1 Yas 2 🗆 N 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

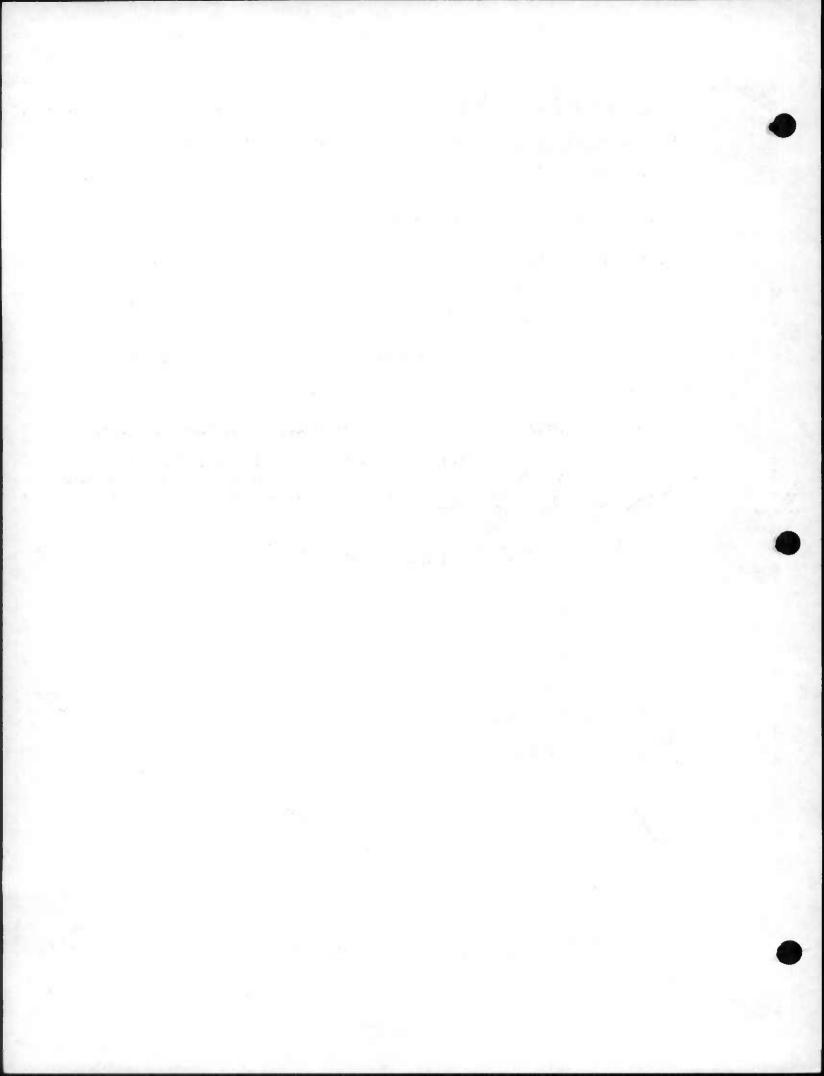
To the Funeral Director: After this certifica completaly filled in by the funarei director, p. Be 25. Was casa raterred to predical axaminar? 28. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 1 Inpatiant 2 ER/Outpatiant 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 - Homicida 1 Certifying Physician: To the best of my knowladga, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to tha ceuse(s) and mannar stated. edicai 29a, Cartifier 29d. Data signad (Month, Day, Yaar) 29b. Signatura and title of Certifian 29c. Licansa number

who complated ceusa of death (Itam 23a) (Type, Print)

State Registrar

31. Data filad (Month

X



State of Maryland / Department of Health and Mental Hygiene 8 1281, 5

				o or ma	· y ·····		rtificate					Reg. No.	1 (.040
	Physician /Medical	Decedent's Name (First, in DANIEL	Middle, Lest) FRANKLIN	DYE	Œ						2. Date of De Month APRIL	Day 15, 1	Year 998	3. Time of Death 6:30 A.N
	Examiner	4a Facility Name (If not inst						4			ation of Deatl	4c. County	of Death	
-	Funeral Director	517 0e11 5. Social Security Number 227–38–8194	6. Sex	7. Age	(In yrs.	last birthday) Yrs.	If Under Months		ELLIC If Under 24 Hours	4 Hrs.	CITY 8. Date of Bir Month, De	BALTIN b, Year) 6,1931		place (State or Foreign ntry) VIRGINIA
ч		Usual Residence of Decede												
	a-f show	MARYLAND BAL	TIMORE			I COTT								10d. Inside City Limits 1 Yes 2 No
	h with the Me 23a or 28a-f s ist be notified al Director	10e. Street and Number 517 OELLA AVE	NUE				10f. Zip		1043			U.S.A.	What Cour	ntry?
020	*natural; or items 23a or 28a-f show collect Examinations by contract at leted by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Dive	Married 1 If Ye	Decedent End Forces? Yes 2 1 Notes, Give r or Dates:			Was Deced If Yes, spec	*	ispanic Origi in, Mexican, Specity:	n? (Spec Puerto R	city Yes or No lican, etc.)	14. Rad Bia Specif	ck, White,	cen Indian, etc. WHITE
21215-0020	ed within 72 horygiena. Frita Medical R. Ire Medical	15. Dec (Specify only if Elementary/Secondary (0	edent's Education lighest grade comple	eted) ege (1-4or 5+)	(Give		k done e retired	ation during most of	of workin	g	16b. Kind of B	usin ess/i n	dustry
	Hiled withi Hygiena.	9TH GRADE		3 (1)		TRUC	K DRIV	VER				BOB TRA		RT
Maryland	Be very								ame (First, Middle, Maiden Sumame) WISECARVER					
Mar	2 sho	19a. Informant's Name/Reis		t)										Code)
Baltimore, 1		NEVA O. DYK 20a. Method of Disposition 1 Burlal 2 Crema 4 Donetion 5 Oth	tion 3 Removal	from State	(517 Oleca of Disposametery, creative VIEV	sition (Nem metory or of	ne of ther plea	ce)		Date	Y,MD.21(20c. Location SYKESV)	- City or To	
Baltin	permit. Page Department of Important: If any Injury or page.	21. Signature of Fundal Se		lann	a	22		d Addre	ss of Facility Funer	-	ome 4	107 Wil	kens	Avenue
	Physician /Medical	23a P. Enter the disease of the control of the cont		that caused to on each line							respiratory a			Approximate Interval Between Onset and Death
	Examiner 5	disease or condition resulting in death)	а	J _C	ue to (d	or as a consec	quence of):	,, ,	Fai Dis	100	0.		1	
	executed in and ial-transit	Sequentially list conditions.	-	Cover	ue to (c	or as e consec	quenca of):	-	1 1218	EU			-	3 years
68760,	ifficate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	с	Em	ph	y Se v	na						,	Syears
Вох 68	E 0.0	resulting in death) Last	d										1	
P.0.	at the d by the latachec	Part It. Other significant co			not res	ulting in the u	nderlying ca	ause giv	en in Part I.		23b. Dld	tobacco use co		o the cause of death?
Vital Records,	Tha law requires the state has bean signer, paga 2 should be completed by	C	eepAp besit	4							24a. Was	an autopsy ormed?	av	fere autopsy findings vailable prior to empletion of cause death?
I Re	Tha law ata hes paga 2										1 🗆	Yes 2 No	1[Yes 200
Viita	cartificata rector, pag	25. Was case referred to me examiner?						104		of Death	(Check only	one)		
to	T digital	1 ☐ Yes 2 No 27. Manner of Death	Hospital:	1 Inpatien Date of Injury		ER/Outpatier 28b. Time o		A Oth	4 U Nur	-		denca 6 Oti		(y)
Division	Par Par	1 Natural 5 P	ending vestigation	(Month, Dey	Year)	Injury	М	1 🗆	k?` Yes 2□N	0				al Pouto Alumbar
Divi			etermined 200.	Place of Injur building, etc.		ome, farm, str	reet, factory	, office		2	City or To		Der OF MUN	el Route Number,
	n 24 hours n 24 hours he Funeral i plately filled edical Ce	29a. Certifier Certifier (Check only one)	tifying Physician: T licat Examinar: On and	o the best of the basis of e I manner state	examina	wiedge, deat tion and/or in	h occurred a vestigation,	at the tir in my o	ne, date and pinion, death	piaca, a occurre	nd due to the d at the time,	cause(s) and m date and placa,	anner as s and due t	stated. o the cause(s)
	To the within 2 To the comple	29b. Signature and title of co		PAA					e number			29d. Date signi		
		D (1)/6	omi	le Holm	2	MD		D 3	388	22		4-	12-	98

Registrar

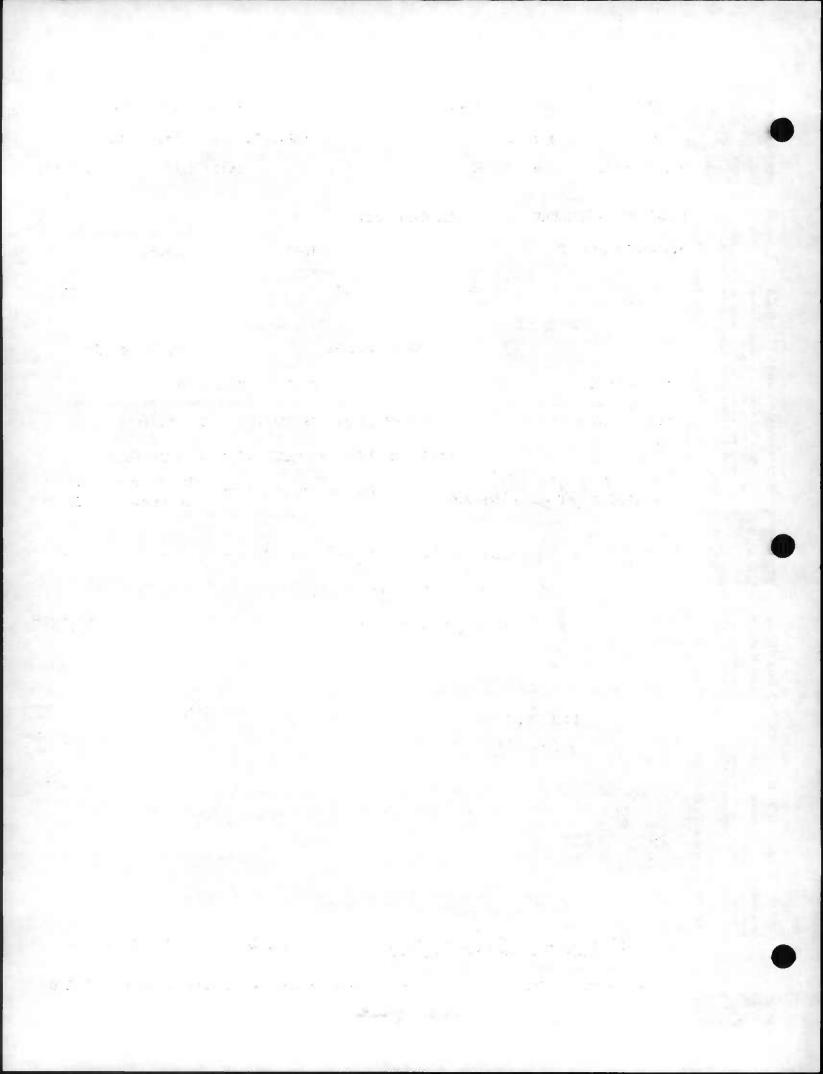
Dr. NAOMI 31. Date filed (Month, Day, Year)

APR 23 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Avenue, Baltimore, MAryland 21229 Julia Davidson

DHMH 16 Rav 6/95



				State of Ma	iryiand		arımenı <i>rtificate</i>			nd Mental H	ygiene	1284	0
	7		1. Decedent's Neme (First, Middle, Las	t)			U I			2. Data of I		3. Time	of Death
п	Physici		Robert R.	Dickerso	n	Jr.				Month Apri	Dey 1 20 19	Yaer 998 11:2	MA OS
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)				4	b. City, Tow	n, or Location of Da		The second second	NO API
			Johns Hopkins	Bayview	Medi	cal	Cente	er	Balt	timore	N/A		
Г	Funeral		5. Sociai Security Number 6. Se	7. Aga	(In yrs. las		If Under 1		If Under 2 Hours	4 Hrs. 8. Date of E		9. Birthpleca (State Country)	or Foreign
L	Director		218-22-1536	X M 2□ F	69	Yrs.	Months	Deys	nours		28 1928	MD	
	pu »		Usuel Residence of Decedent 10a, Stata 10b, County		10- 04-	T							
	anyla shon	-	Md Baltimo			Town or Lo						10d. Inside (
	Me M	Director		ire	Bal	timo	-						s 2⊠No
	vith t	E C	10e. Street end Number				10f. Zip C				10g. Citizen of \	Whet Country?	
	23	Funeral	622 S. 47th St					122			USA		
	er de item	ű,	11. Maritel Stetus	12. Was Decedent E Armad Forcas?		13.	Was Decade If Yas, specif	nt of His y Cuber	spenic Orlg n, Maxican,	in? (Specify Yes or I Puarto Rican, etc.)		e - Amaricen Indien, ck, White, atc.	
20	s aft	by F	1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes:	0		1 ☐ Yes 25	⊘ No	Specify:		Specify	White	
8	72 hours after death with the Manyand natural; or items 23s or 28s-f show drall Examiner must be notified as	P P	15. Decedenl's Edi			160 Daca	dent's Usuel	Occupa	tion		16h Kind of B	usinass/Industry	
15	in 72 n na lealic	olet	(Specify only highest grad	de completed)		(Give	kind of work DO NOT use	done d	uring most	of working	TOD. KING OF BI	isiiassiiigustiy	
212	within iene. than "	Completed	Elementery/Secondery (0-12)	College (1-4or 5+	+)		eman				Beth	- Steel	
p	e filed al Hygi other vent,	BeC	17. Fether's Neme (First, Middle, Last)					T	18. Mother	's Name (First, Midd			
Maryland 21215-0020	should be and Mentel a marked or turnatic eve	To B	Robert R. Dick	erson					Rob	erta Ir	ene Wat	son	
any	end N		19e. Informent's Name/Reletionship (T	ype, Print)		19b. Meili	ng Address (Street e		or Rural Route Nun			- X, II
	DENE		Juanita Dicker	son /wi	fe	622	S. 4	17tl	n St.	Balt	imore,	MD 21224	
ore	of He standard		20a. Method of Disposition		20b. Pled	ce of Dispo	sition (Neme metory or oth	er plece	9)	Date		City or Town, Stata	
Ĕ	Page Int: If		1 ☐ Burial 2 ☑ Cramation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,			-	Crema			Apr. 23	Catons	sville, M	4D
Baltimore,	permit. Pages 1 en Department of Heal Important: If item 2 any Injury or other 2005.		21. Signeture of Funerel Service Licens	100	110	2	2. Name end	Addres	s of Eacility	neral Ho	no of D	varie, r	10
m	88558		Mutlow Co	+(~	00.	/				Point			
			23a. Pertf. Entar tha disall e, or comp shock, or heert fallure. List only of	lications that caused l	the death.	Do not en				ardiac or raspiratory		Approxime	ete
	Physician		Shock, of fleet failure. List only o	The couse on each line	U		20		- 1			Onset end	
	/Medical		Immediate Ceuse (Finel disease or condition	Acute	Ke	SPIRE	tory	ta	ulur	Q			
	Examiner		resulting In deeth)	0 1	Due to (or e	es e consac	quance of):		0	1	2		
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	tificete be executed g physician and as the burial-transit	хаш	Sequentially list conditions,	С.	Due to (or e	s e consec	quence of):				8		
60,	cian	E I	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	c									
68760,	physis the	edical	thet initieted events resulting In deeth) Lest	D	ue to (or e	s e consec	quenca of):						
-	ding		L.	d									
Box	death certif e ettending id for use a	Physician/M										1	
o		iysi	Pert II. Other significent conditions co	ntributing to deeth but	nol resulti	ing in tha u	nderlying cau	use give	n in Pert I.			ntribute to the cause	
Q	es that the death certifigned by the ettending be deteched for use a									1(Tes 2□ No	3 Probably 4□	Unknown
Records,	requires that the	d by								24a. W	as an autopsy	24b. Were autopsy	findings
00	- LI (5)	Completed								pe	formed?	eveilable prior complation of deeth?	cause
Re	The law ate has b page 2 si	m								4.5	14		1
	iclan: The certificate rector, pag		25. Was cese referred to medical						00 Di		Yes 2⊠No	1 □ Yes 2 0	No
Viita		o Be	examiner?	Hospitel: 1 ☐ Inpatien		2/Outerties	- 2 DOA	Othe		of Death (Check only		as (Casaifa)	
ō	4 5 2	-	27. Menner of Deeth	28e. Date of Injury	/ 2	R/Outpatier 8b. Time o		c. Injury Work		sing Home 5 ☐ Re 28d. Describ	e how injury occur		
Division	if or Attending P is efter deeth. I Director: After t d in by the funera	ertification:	1 ☐ Neturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey	Year)	Injury	M		.? ⁄es 2 ☐ N	lo			
N S	Attend or deeth octor: by the	110	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injur	ry - At hom	e, ferm, str	reet, factory,	office				per or Rural Route Nu	m <i>ber</i> ,
Ö	s effe s effe al Dire	Cert	- CI FIGURIO	building, efc.	(Specify)					City of 1	own, Stete)		
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in		29a. Certifier (Check only 2 Medical Exam)	eician: To the best of	my knowle	edge, deatl	n occurred et	the tim	e, date end	place, end due to the	e ceuse(s) end me	enner es steted.	(a)
	he H in 24 he Fi	edicai	one)	ner: On the basis of e end menner state	ed.	n end/or in	vestigetion, if	пту ор	irilon, deeth	Occurred of the tim	s, date end piece,	and due to the ceuse	(9)
	with To t	Σ	29b. Signature and title of certifier				29c.	Lieense	number	7	29d. Date signe	d (Month, Dey, Year)	
			·		0			VI	142		7/2	MYX	

5601 Loch Raven Blvd. Baltimore, MD 21239

State Registrar 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

M.D.

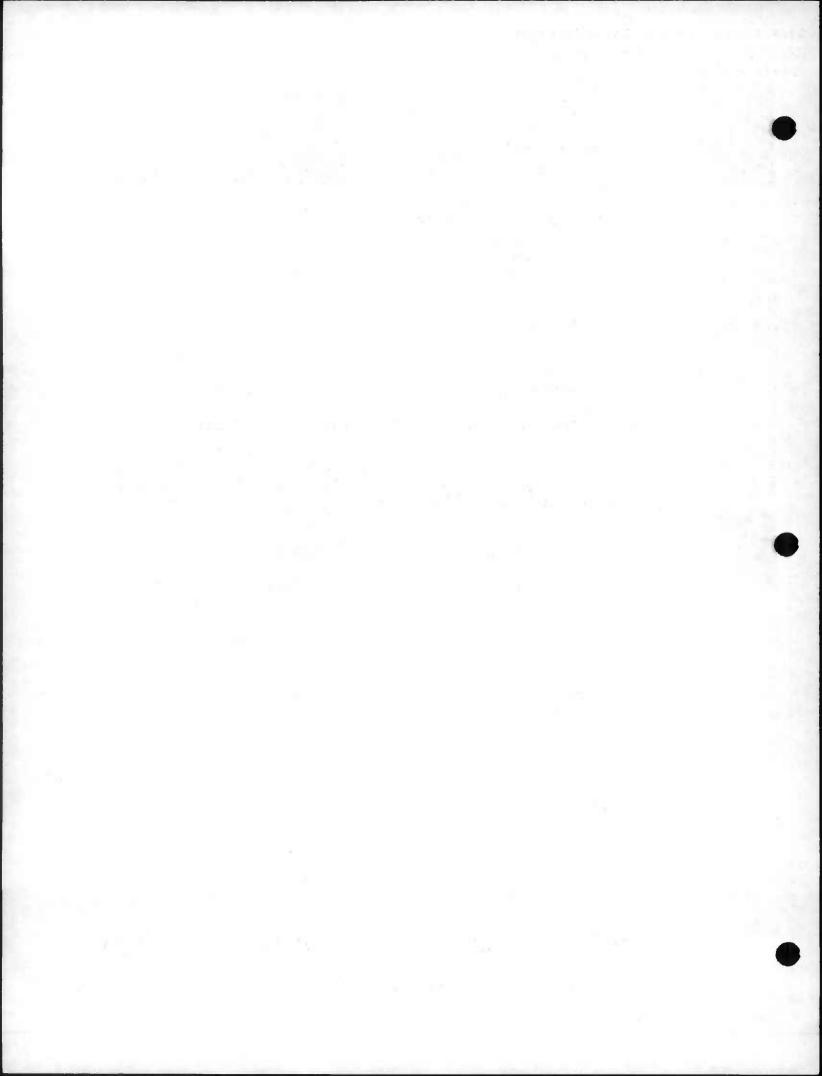
32 Registrer's Signeture Julia Davidson-Randall

Edward M. Miller,

APR 23 1998

31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** Decint Angelo A. April 1998 22 5:00 AM /Medicai 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 8823 Chesapeake Ave Baltimore Edgemere if Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev, Year) Birthplece (State or Foreign Country) Months Days 1XM 2□ F 83 Yrs 212-03-1748 Aug 2, 1914 MD Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. inside City Limits Edgemere 1 ☐ Yes 2 No Director MD Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21219 USA 8823 Chesapeake Ave Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Reca - American Indian, 11. Marital Status Bleck. White, etc. 1 XYes 2 No If Yes, Give Year or Detes: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced 1945 White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Patapsco & Back Elementery/Secondary (0-12) College (1-4or 5+) Rivers Railroad Motor Car Operator 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Josephine Plockie August Decint 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Decint /wife 8823 Chesapeake Ave Edgemere, MD 21219 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Date Apr. 25 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) Oak Lawn Cemetery Baltimore, MD 21. Signeture of Funerel Service Licenses ²² Name and Address of Funeral Home of Dundalk Sollers Point Rd 7110 hony ON 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feiture. List only one cause on each line. Approximate interval Between Onset end Deeth Immediate Cause (Final diseese or condition resulting in deeth) Due to (or as a consequenca of) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 20 No 3 □ Probably 4 □ Unknown 1 Yes ð 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to Completed completion of ceuse of deeth? 1 ☐ Yes No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) P 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and placa, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 29c. License numbe w V 30. Neme end eddress oberson who compiled ceuse of deeth (Item 23e) (Type, Print) 6701 N. Charles St Benjamin Yorkoff, M.D. Towson, MD

State Registrar

31. Date filed (Month, Day, Year) APR 23 1998

32. Registrer's Signature

whe Newidson-Randell

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Funeral

Director

item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene Important: if hem 27 is marked other than 'n any injury or other traumatin auch.

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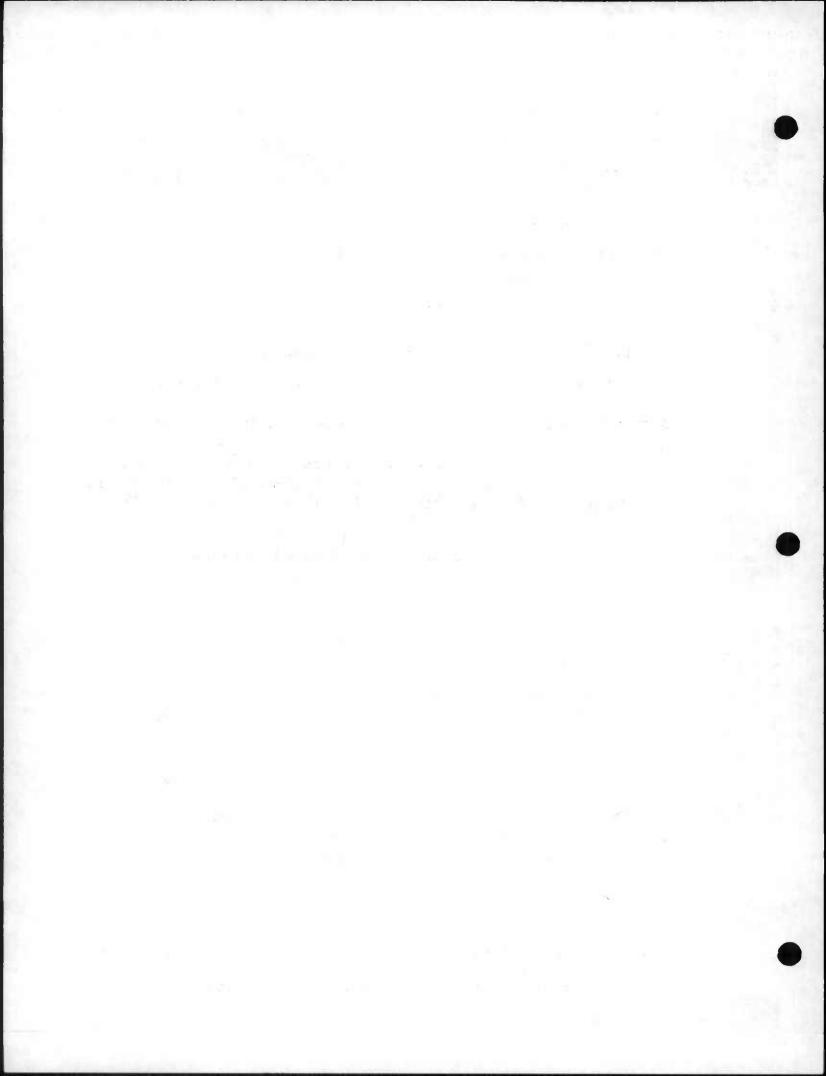
Box 68760 certificate be

Division of Vital Records, P.O.

with the Maryland

72 hours efter deeth

altimore, Maryland 21215-0020



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	Physic	ian	1. Decedent's Name (First, Middle,								2. Date of De	ath	ay	Year	3. Time of	Death
u	/Medi		Thomas E. Emor	-							April		199	8	8:00	A.M.
ľ	Exami	ner	4a. Facility Neme (If not institution, § 3631 Ash Street	give street and nu	ımber)				4b. City, To Balti		ocation of Deat		c.County Balti			
	Funeral Director		217-34-3360	5. Sex 1⊠M 2□ F		yrs. last birt.	rhday) Yrs.	If Under 1 Yea Months Deys		24 Hrs. Min.	8. Date of Bi (Month, Di Apr. 20	ay, Yea		Coun	elece (State of etry) 1 land	or Foreign
	and w		Usual Residence of Decedent 10a, State 10b, County		10	c. City, Town	or Loc	ation						10	0d. inside Ci	ity Limits
	he Mary 28a-f sho ptimed a	Director	Maryland Baltimo	ore		Woodl	.awn								1 🗆 Yes	
	23a or 2		3631 Ash Street					10f. Zip Code 21211						Whet Coun State	,	
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Maryland	should be filed nd Mental Hygid marked other umatic event, to	To Be C	17. Father's Name (First, Middle, La Thomas W. Emory						e (First, Middle Willi:		an Suman	ne)				
	1 end 2 sho Health end N em 27 ie ma other traums		19e. Informant's Name/Relationship Kathryn E. Gesch						ral Route Number, City or Town, State, Zip Code) nthicum, Maryland 21090							
Baltimore,	age anto r: F		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special Control of Control	Stata	ceme ter)	v. crema	Date April 20c. Location - City or Town, State April 20c. Location - City or Town, State 22, 1998 Catonsville, Mar							land		
Balt	permit. Pa Depertmen Important: any injury once.		21. Signature of Fortural Service Lic	url L				_	ry, Inc. 22, 1998 Catonsville, Mary d Address of Facility y-Ruddick Funeral Home, P.A. ain Hwy., S.E., Glen Burnie, MD 21061							
ox 68760,	Physician //Medical Examine physicien en ding physicien en physicien e	/Medical Examiner	immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Porce	okere	ellas.	CARNIAL IN FAICTION CARNIAL IN FAICTION consequence of): ARDVOVASCULAR DISCASE consequence of): Carlar Dislase, Severe . consequence of): Carlar Dislase, Severe . Consequence of): Carlar Dislase or Herroliflysis							Onset end D	Death	
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37			30. Nam and eddress of person wh	cysol o completed caus		(Item 23a) (1	Туре. Р	D rint)	052	97		Ap	ril	21, 1	.998	
			Jerome Koeppe	1, 222 V	V. Co.	ld Spr	ing		Baltim	ore,	MD 21	L210)			
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Registrar

State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ABT11 23 Day 1998 Yeer **Physician** Jacob Albert Frederick 710 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Reisterstown 518 Berrymans Lane Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Oct. 31,1926 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Hours Months Mary Land 219-20-0074 1**X** M 2□ F 71 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Reisterstown Baltimore 1 ☐ Yes 2 No Md. Director 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21136 518 Berrymans Land Funerai death 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No It Yes, Give Yeer or Detes: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Maritel Status filed within 72 hours after 1 Never Married Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry / Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Suburban Propane Driver 12 other 1 18. Mothar's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) s 1 and 2 should be fit I Health and Mental H tem 27 Is marked out Be Ethel Mae Ruby Jacob A. Frederick 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a 518 Berrymans Lane, Reisterstown, Md. 21136 Elaine P. Frederick altimore, 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition Important: If Its any Injur 1 Burial 2 Cremation 3 Removal trom State Evergreen Mem. Gardens Apr. 25, 1998 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Servica License 11605 Reisterstown Rd., Owings Mills, Md. 23a. Pert1. Enter the shock, or haer ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. List only one cause on each line. Approximate tntarval Batween Onset end Death **Physician** melastation Prostel Cancer /Medical Immediate Cause (Final 75 disease or condition resulting in death) Examiner Examiner physician and s the burial-transit certificate be axecuted Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca ot): Box 68760. Physician/Medical Due to (or es e consequence of): 50 esn ō ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 20 No 3 Probably 4 Unknown be del Records, by 24b. Ware autopsy tindings aveilable prior to completion of cause of death? 24a. Was en autopsy Completed peen page 2 s 1 Yes 21 No 1 Yas certificata Division of Vital or Attending Physician: funeral director 25. Was case raferred to medical Be 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Sesidenca 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner ot Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Investigation 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homleida Hospital 29a. Certifian 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, data and place, and dua to the ceuse(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) end manner stated. completaly (Check only one) To the To the T 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number -12550 ddrass ot person who complated cause ot daath (Itam 23a) (Type, Print) 12 7801 QUINLOW JOL YURK RD Torson MD 21264 12.

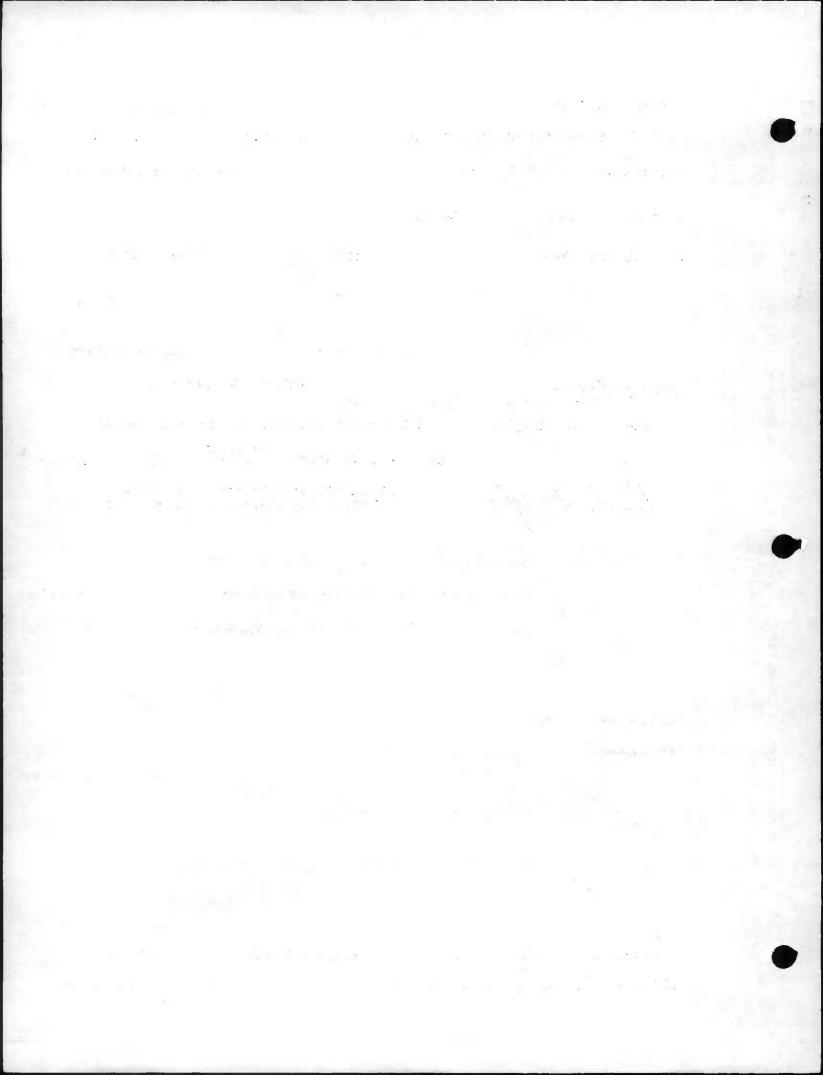
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Funera	al	5. Social Security Number	6. Sex	7. Age (In yr.	s. last birth	day) If Under 1			8. Date of B (Month, D	irth .	9. Birthple	ece (State or Foreign			
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		Beverly Dotson / Daughter 823 Barbara Ct., Glen Burnie, Marylan													
ore, M les 1 end 2 of Health of Health of them 27 li		20a. Method of Disposition		Dete	20c. Location										
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Baltimore, permit. Pages 1 er Department of Hea Important: If Item 2 any Injury or other	i De	21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A.													
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OD OD Oding Pt After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pendin		e of injury onth, Day Year)	28b. Tii	me of 280 jury	c. Inju		28d. Describe	how injury occur	rred				
Division of Vital Records, for attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be one Bloc	no of Initial At	home for	M dreat factors		Yes 2 No	28f Location	(Street and Num	her or Rural	Poute Number			
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filled filled	2		g Physician: To th	ne best of my kr	nowledge,	death occurred at	the ti	ime, date end plece,	and due to th	e cause(s) and m	enner as sta	ated.			
Division of Vita To the Hospiral or Attending Physicien: within 24 hoors after death. To the Edineral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical one)		besis of examination of the state of the sta	netion and/	or Investigation, l	n my c	opinion, death occur	red at the time	e, date and place,	and due to	the cause(s)			
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		30. Name and address of person		_	em 23a) (T			en Dr.				2.6.			
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Registrar

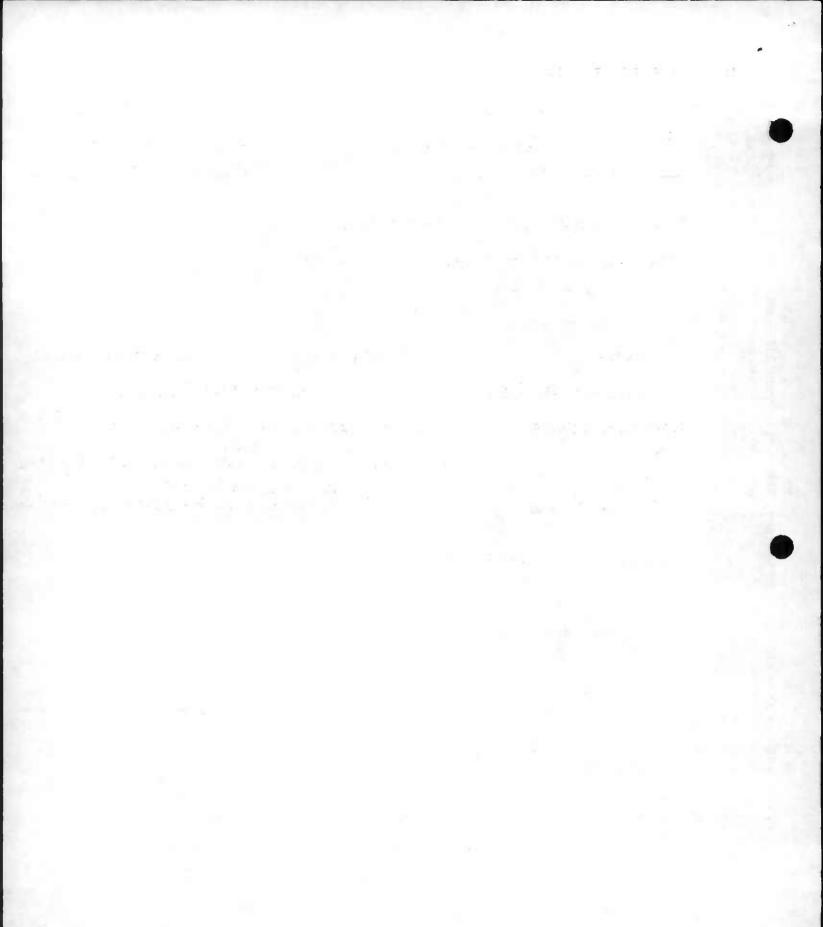
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31. Date filed (Month, Day, Yaar)

32. Registrar's Signature
Julia Davidson-Randate

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Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month APRIL 4a Facility Nama (If not Institution, giva street and number) 168 2 2 Rock SPRING ROAD 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Director 8. Data of Birth Month, Days Hours Min. 10a. State 10b. County 10c. City, Town or Location FOREST HILL 10b. County 10c. City, Town or Location FOREST HILL 10c. City, Town or Location	Day Year 3 P.M. 4c. County of Death HARFORO Syear) 9. Birthplaca (Steta or Foreign Country)
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Examiner 4a Facility Nama (If not Institution, giva street and number) 168	4c. County of Death HARFORO 9. Birthplaca (Steta or Foreign
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TORNAN HARFORD FOREST HILL 109. Street and Number 101. Zip Code	10d. Inside City Limits
10e. Street and Number 10f. Zip Code	1 ☐ Yee 28 No
E to Street and Control	Og. Citizen of What Country?
(2002)	i) C
23 13 Rock SPR No 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Amarican Indian,
11. Marital Status 12. Was Decedent Ever in U.S. Armad Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armad Forces? 14. Marital Status 15. Never Married 16. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married	Black, White, etc.
If Yes, Give Year or Dates: Visto An	Specify:
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	20c. Location - City or Town, State
	DARLINGTON, MARYADO
	- BIL AIR, P. A.
Track To Chap In 3 (15) NORT DRIVE TO	SCIET HIT I JAKALAN
23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory are shock, or heart failure. List only one cause an each line.	est, Approximate Interval Between Onset and Death
Physician Medical Immediate Cause (Final disease or condition A S C V I >	
disease or condition resulting in death) Due to (or as a consequence of):	
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Due to (or as a consequence of):	
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State of Maryland / Department of Health and Mental Hygiene 8 | 2853

						(Certifica	te of	Death			Reg. No.		
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	Physician /Medical	ANISC	CETA DEJES	US GEWIR	TZ						APR:	IL Byo,	1998	10:20 P
	Examiner	4a Facitity	Nama (If not instituti int Jose	on, giva street and	number)	enter				own, or L	ocation of Dea	th 4c. Count		imore
	Funeral Director		ecurity Number 14–2849	6. Sax 1 ☐ M X F	7. Aga (In y	rs. last birth	Months	ar 1 Yaar Days		24 Hrs. Min.	8. Data of Bi (Month, D Feb • 13	irth 8, 1946	9. Birthple Count Mary	aca (Stata or Foreign ny) Land
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	e Marylar Se-f show Effed at	MD MD	N/A	ry		City, Town							10	d. Insida City Limits 1X Yas 2 □ No
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lar	and is me		nant's Name/Ralation	nship (Type, Print)		19b.	Mailing Addras	ss (Stree	t and Numb	er or Ru	ral Route Numi	ber, City or Town	, Stata, Zip	Coda)
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Baltimore,	Page at: #	1 □ Bu	d of Disposition urial 2		om Stata	cematary	Disposition (Na , cramatory or Mount	othar pla		y 4	Data -22-98	20c. Location Baltim		
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of V	2 0 5	1 ☐ Ya		Hospital:	Inpatiant 2	2 ☐ ER/Out	patient 3 0	JUA		ursing H	oma 5□Ras	sidance 6 🗆 O	har (Specify)
Division o	To the Hospital or Attending Ph Within 24 hours after death. To the Fureral Director: After thi completely filled in by the funeral Medical Certification:	27. Mannar 1 Na 2 Ac	tural 5 Pand invas	ling (M tigation	ete of Injury Ionth, Day Year	28b. Ti	ma of jury M	28c. Inju Wo	uryet ork?]Yas 2□) No		how injury occu		
Divi	s after d M Direct ed in by	3 Su 4 Ho	deter	mined 288. Pli	ca of Injury - At homa, farm, street, factory, office Iding, atc. (Spacify) 28f. Location (Streat and Number or Finding, atc. (Spacify)					ber or Rura	l Routa Number,			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification	29a. Cartifi (Check one)		i Examiner: On the		e bast of my knowledga, daath occurred at tha tima, data and placa basis of axamination and/or Invastigation, in my opinion, daath occu nnar stated.								
	Vithin To the comp		tura and titla of certif		2	9c. Lican	sa numbar			29d. Data sign	ad (Month, I	Day, Year)		
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	20		and eddress of person	30, M.D.			Type, Print)	D,	TOWS	on,	MARYL	AND		
	State Registrar	31. Data fil	ad (Month, Day, Yea	3 1998	2. Registi de Si	Davidse	n- Randa	02.						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month 1998 HURLBURT 1:45 P.M JORDON 22LSAH.7 APRIL 21 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) (20AO 2424 HARKINS HARFORL 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Months DELM 2□ F TO 066 22 5864 Usuel Residence of Decedent Yrs FIB.10, 1928 MASSACHUSETTES 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 28 No HARFORD WHITZ DARVERO 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A 2424 HARKINS KOAC 21161 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Medtel Stetus 1 ☐ Never Merried 250 Married Specify: WHITE 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Services SEALAGO 12YRS. 2 YRS. APTAIN 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) HURLBUR LILLIAN VON KEUDAL 50R000 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3,015 19e. Informent's Name/Reletionship (Type, Print) BELRIR MARYLAND 20c. Location City or Town, Stete TRUDITHOILISTONAL PEP ADD L. HURLBURT 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) APRIL23 20a. Method of Disposition 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) POUNT LREMATOR 1998 BALTIMORY 21. Signeture of Funeral Service License 22. Name end Address of Fecility CHAPEL-BELATR, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. FORSOT HUL MARYLAND Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) ASWID Due to (or es e consequence of): Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Pert II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yea 2 No 3 Probably 4™ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Funeral

Director

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72 hours after

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Hygiene

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Pages 1 and 2 and 2 and 1 and Hem 27 i

permit. Pages Department of Important: If ih

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Baltimore, Maryland 21215-0020

attending physician end for use as the burial-transit tha signed by t peen : cartificata has Aftar this funeral

The law requires that the death cartificate be executed

P.O. Box 68760,

Division of Vital

Physician:

or Attending

aftar 24 hours

within 2

I Director: A daeth

edicai

State

Registrar

29a. Certifier

(Check only one)

Physician/Medical Examiner þ Completed 25. Was case referred to medicel exeminer? Be 2 Certification:

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

26. Piece of Death (Check only one)

Hospital: Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 1 Naturel 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28e. Dete of Injury (Month, Dey Year) 28b. Time of NA NA 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred NA

24a. Wes en eutopsy performed?

1 ☐ Yes 2 No

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

29b. Signature end title of certifie

29c. License number CME

DME 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

218 FULFOND ALE BELAN MD 21014 RABHU

GANS 31. Dete filed (Month, Day, Year)

32. Registrar's Signature who Davidson Brindall

DHMH 16 Rav 6/95

Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

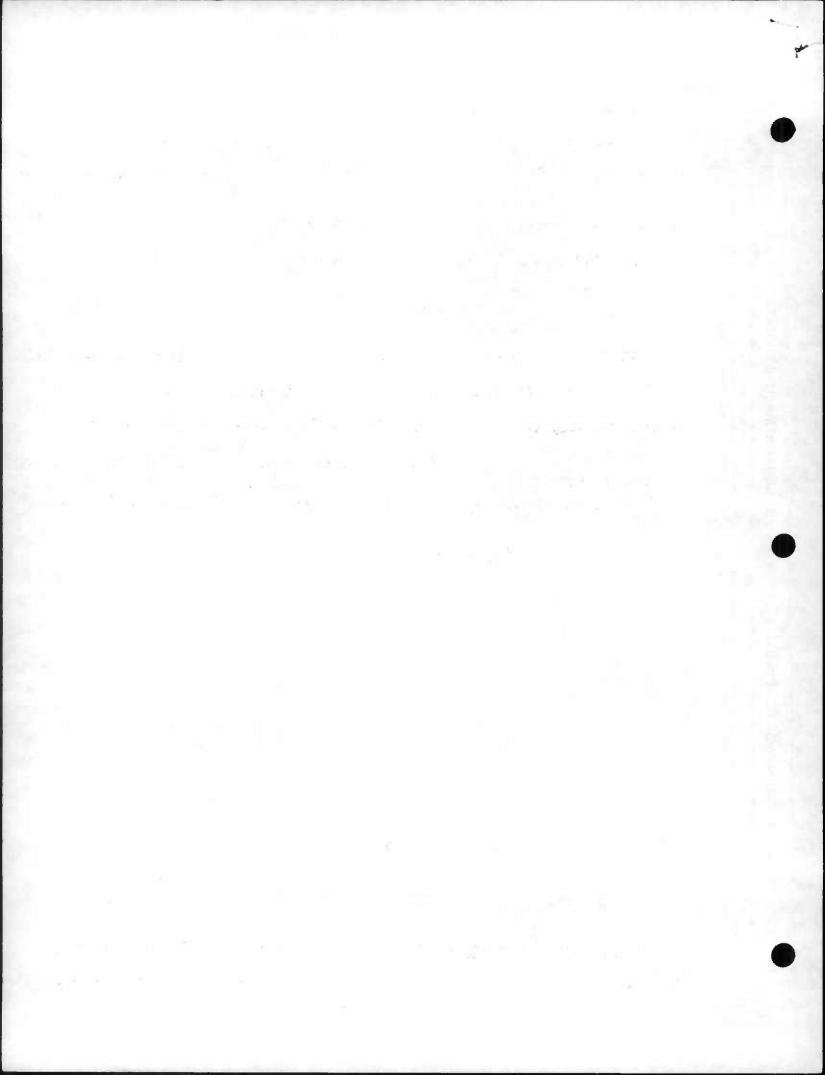
24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Location (Street end Number or Rural Route Number, City or Town, Stete)

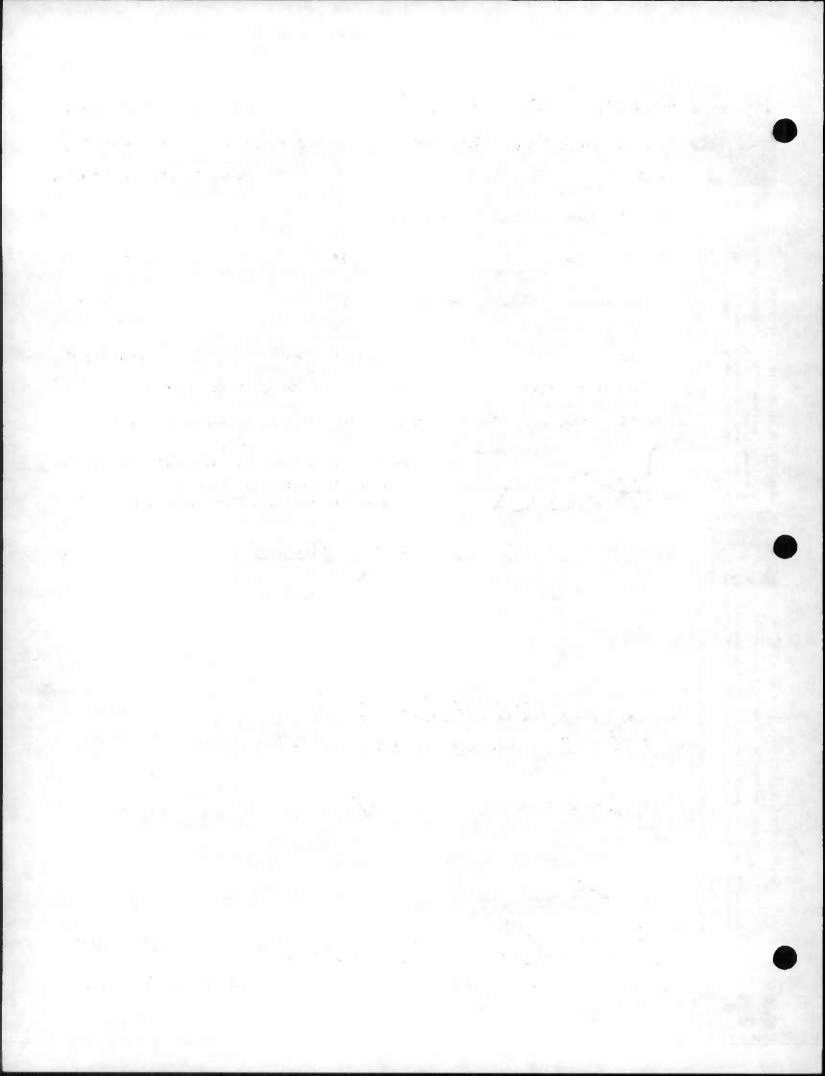
29d. Dete signed (Month, Dey, Year)

APNIL 21 1998



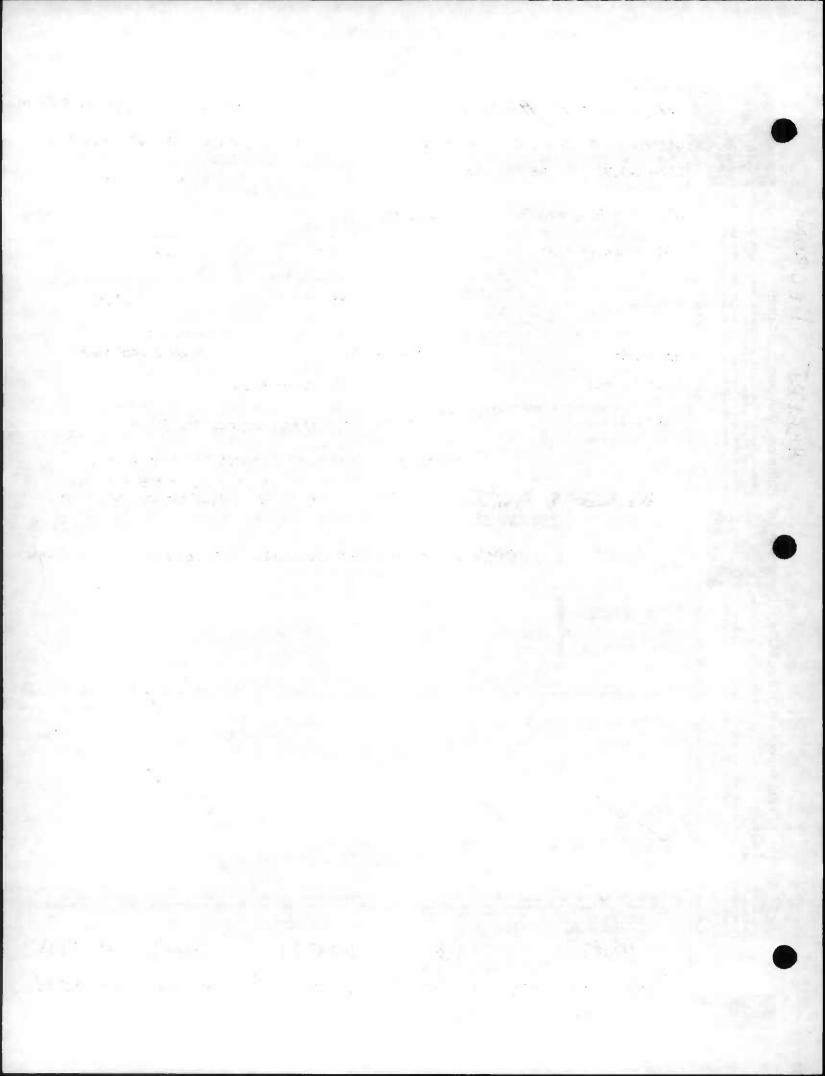
State of Maryland / Department of Health and Mental Hygiene 285

		Certificate of Death	Reg. No.
	1. Decedent's Name (First, Middle, Last)	2. Data of I Month	
Physician Medica	FRANK M HICK	S APRIL	20,1998 1:15Pm
Examine	4a Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of De	ath 4c. County of Death
	NORTH APUNDEL HOSPITA	L GIEN BURNIE	A.A. COUNTY
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last by	Months Days Hours Min. (Month,)	Birth 9. Birthplace (State or Foreign Country)
Director	238-01-3126 81	Yrs. Sept.	
pu ≱_	Usual Rasidanca of Decedent 10e. State 10b. County 10c. City, Toy	wn or Location	10d. inside City Limits
sho sho		Burnie	1 ☐ Yes 2月No
or 28a-f s	10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
with with	706 2 111 2		
tilled within 72 hours efter death with the Maryland the Hygiene. other than "natural", or items 23s or 28s-f show yent, the Medical Examinal must be notified.	726 Biddle Road 11. Maritel Status 12. Was Decedent Ever in U.S.	21061	United States No- 14. Race - American Indian,
ter d	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yas 2 □ No	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
72 hours of natural, or dical Exam.		1 ☐ Yes 2 ☐ No Specify:	Specify: White
2 hou	15. Decedent's Education 168	a. Decedent's Usual Occupation	16b. Kind of Business/Industry
ed within 72 ho ygjene. or than "naturi ft, fre Wedeal	(Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
filed within Hygiene. ther than "	12	Restaurant Work	Self-Employed
d 2 should be file th and Mental Hy 7 is marked othe traumatic event.		18. Mother's Name (First, Midd	dle, Maidan Sumama)
Abrit Abrit		Beaula Pearl	l Slagle
and a	,,,,,,,	b. Malling Address (Straat and Number or Rural Route Num	nber, City or Town, State, Zip Code)
を有なさ	F. Martin Hicks, Jr. / Son P	.O. BOX 2824 Lenoir, N. Car	colina 28645
T de T	20a. Mathod of Disposition 20b. Place of cermets 2 Cremation 3 Removal from State	of Disposition (Name of ery, crematory or other placa) Date April	20c. Location - City or Town, State
Pages hent of int: If it ary or o		ownsville Vet. Cem. 23, 199	OS Crownsville, MD
semit. Pages 1 a Papartment of Hea mportant: If Nem my Injury or othe MGS.	21. Signature of Fundral Service Licensee	22. Name and Address of Facility	Town 6
SEES	11/2 m	Kirkley-Ruddick Funeral F 421 Crain Hwy. S.E. Glen	
	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardlac or respirator,	y arrest, Approximata
Physician	snock, or neart failure. List only one cause on each line.	2 2	Intarval Between Onset end Deeth
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0 02 7	Part II. Other significant conditions contributing to death but not resulting	In the underlying cause given in Pert i. 23b. D	id tobacco use contribute to the cause of death?
that the ad by th detachs	Promises Museulial Rules to	s. Change	☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
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The law requires are has been eign page 2 should be	destintial and design (a		as an autopsy available prior to completion of cause
has be	continued the first ac, and		of death?
The The page		11	☐ Yas 2☐No 1☐ Yes 2☐NO
S 50 8	25. Was case rafarred to medical	26. Place of Death (Check on	ly ona)
Physician: The cartificate rail director, per To Be Co	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3 DOA Other: 4 Nursing Home 5 Re	esidence 8 Other (Specify)
Ter Atlanding Pi Stra Ceath. Official: Atlant Official (in linear	27. Manner of Death 1 2Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	Injury Work?	be how injury occurred
The Party of	2 Accident investigation	M 1 Yes 2 No	
affer Attending P s lates death. TOTEGOR: Abart BOTTEN, the latest	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	erm, street, factory, office 28f. Location City or	n (Street and Number or Rural Route Number, Town, State)
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n 24 houp n 24 houp ne Fulle pletery fill		ge, daath occurred at tha tima, date and place, and due to t nd/or investigation, in my opinion, daath occurred at tha tim	
Series Paris	one) and manner stated.		
To the within To the comple	29b. Signatetie and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
	Voge M. Mamerish	1) 036256	4/15/18
	30. Name and address of person who completed cause of daatii (Item 23a)	(Type, Print)	
)	Sonce M. Homine 2 Mb 18451	Dakwood Rd Se 201 Glenb	rail MO ZICLEI
State	31. Dam Hust Morily, Day, Year) June 192. Registrar's Sight Duray	alla	
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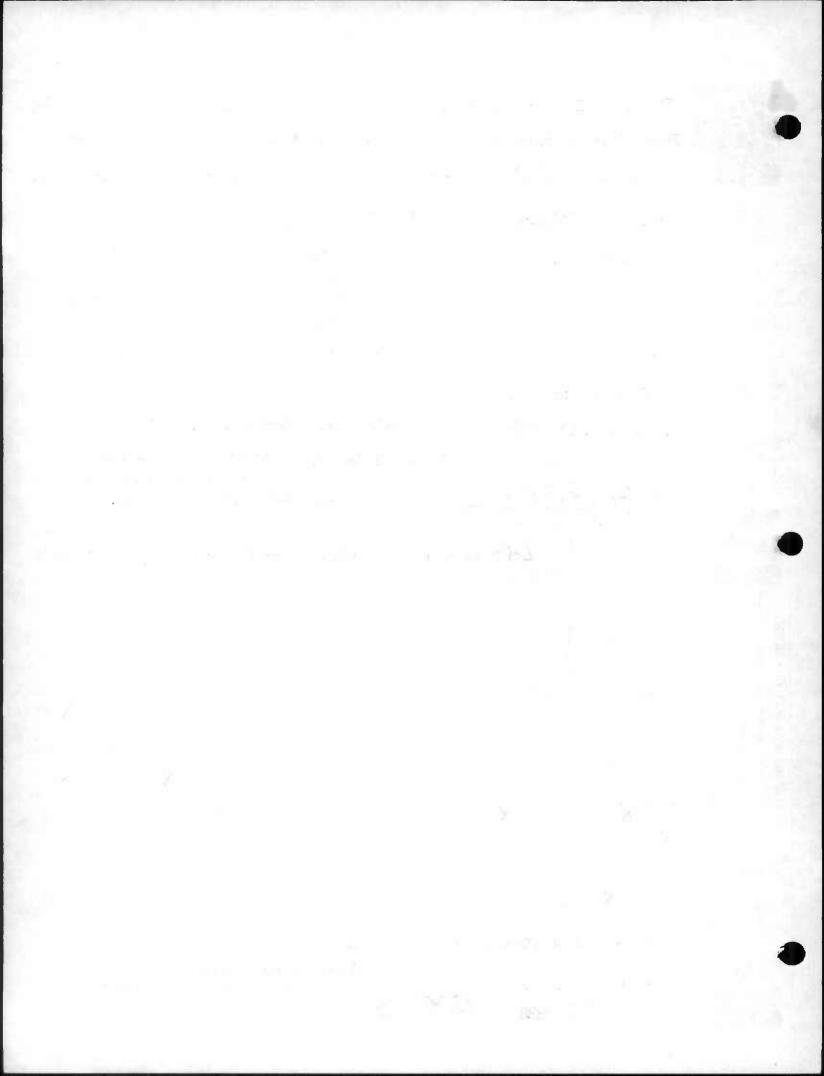
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	1. Decedenfa Nan	ne (First, Middle, La	st)					2. Dete of De			3. Time of Death	
cian	4110	RT E.	HER	0011				AMonth!	Day	45°2	10:05 A.m.	
cal ner		(If not Institution, giv					4b. City, Town, or	Location of Deatl		of Death		
iei		1 ARUN			TAI		GLEN	RIPALIE	ANINE	= AR	UNDEL	
	5. Social Security I			7. Age (In yrs.	last birthday) If L	Inder 1 Year	If Under 24 Hrs	8. Date of Bir	th		lace (State or Foreign	
	217-05-1	479	1 2□ F	83	Yrs.	nths Days	Hours Min	July 1	9, 1914	Md.	ury)	
-	Usual Residence of	of Decedent 10b. County		100 Ci	ity, Town or Location					1	0d. Inside City Limits	
	Md.	Anne Ar	undel	100.00	Hanover						1 ☐ Yes 2☐No	
Director	10e. Street and Nu	umber			10	f. Zip Code			10g. Citizen of V	What Coun		
5		lkner Roa	d			2107	6		USA			
runerai	11. Merifel Sfafus		12. Wes Deced		J,S. 13. Was [Decedent of	Hispanic Origin? (Specify Yes or No)- 14. Rac	e - Americ		
Dy ru	1 Never Mar	rried 2 Married	Armed Ford 1 Tyes 2 If Yes, Give					to Hican, etc.)		ck, White,		
	3. Widowed	4 Divorced	Year or Da	tes:	, , ,	es 2 No	эрвспу.		Specin	Blac	:k	
e G	(Spe	15. Decedent's Educify only highest gra	ducation ade completed)		16a. Decedent's (Give kind	of work done	during most of we	orking	16b. Kind of B	usiness/ind	dustry	
Completed	Elementary/Sec		College (1-	4or 5+)	Contract	OT use retire	90)		Self-E	mplow	for	
	8th Grade	(First, Middle, Last))		COLLCEGO	LOL	18, Mother's Na	me (First, Middle			cu	
Ď.	Frank Hel						Mabel S					
To	19a. informant's N	Name/Relationship (Type, Print) da	wahter	19b. Mailing Ad	dress (Stree	t and Number or F	ural Route Numb	er, City or Town,	ity or Town, State, Zip Code)		
	Arlene Wa	Warren 7110 Faulkner Ro					Road Ha	oad Hanover, Md. 21076				
	20a. Method of Dis		20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To						Town, State			
	1 by Qurial 2 4 ☐ Donefion	Cremefion 3 5 Other (Specif	JRemoval from S y)		nts Rest			April 24	Harmon	rmons, Md.		
	21. Signature of F	uneral Service Licer	nsee		22. Nar	ne and Addr				eral Homes, Inc		
21. Signature of Funeral Service Licensee 22. Name and Address of Fecil								Falls PKWY Baltimore, Md. 21216				
	23a. Part1. Enter	the disease, or com	4				Gwynns Falls PKWY Baltimore, Md. 21216 ode of dying, such as cardiac or respiretory arrest, Approximate					
Physician /Medical Examiner Examiner	Immediate Cause disease or condition	ert failure. List only (Final	one cause on ea	ich line.			ing, such as cardie				Approximate Interval Between Onset and Death	
edical	Immediafe Cause	onditions, mmediate lerving in Injury ts	one cause on ea	Due to (20 V f e of):					Approximate Interval Between Onset and Death 2 day \$	
edical	Immediate Cause disease or conditi- resulting in death) Sequentially list cri- if any, leading to it cause. Enter Und Cause (Disease or that initiated event	onditions, mmediate lerving in Injury ts	one cause on ea	Due to (OFPES (or as a consequence) or as a consequence	20 V f e of):					Approximate Interval Between Onset and Death 2 days	
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by mysicial emedical	Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	ent failure. List only (Final on on on on on on on on on on on on on	a. A A A A A A A A A A A A A A A A A A A	Due to (c	CERENCO OF AS A CONSEQUENCE OF AS A CONSEQUENCE	20 \ f e of): e of):	Benias	23b. Dld	AEN)	3 ☐ Proi	o the cause of death? bably 4 Unknown ere autopsy findings ellable prior fo	
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o se Completed by Physician/Medical	Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) Part II. Other significant of the condition of the cause of t	onditions, mmediate errying to Injury ts Lasf inficant conditions c	b c thospital: 100n 28a. Date of (Month)	Due to (c) Due to (c) Due to (c) Ath but not res	OFFENO or as a consequence or as a consequence or as a consequence sulting in the underly	e of): e of): ying cause g	iven In Part I. 26. Place of Drither: 4 \(\text{Nursing} \)	23b. Did 1 □ 24a. Was perference to the control of	tobacco usaco Yes 2 No san autopsy ormed? Yes 2 No	3 Prol	o the cause of death? bably 4 Unknown ere autopsy findings ellable prior for mpletion of cause death? Yes 2 No	
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ledical Certification: To Be Completed by Physician/Medical	Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) Part II. Other significant of Death (Part III) 25. Was case referexeminer? 1 Yes 2 27. Mange of Death (Part III) 29. Accident 3 Suicide 4 Homicide 29a. Certifler (Check only)	onditions, mmediate eriving in Injury is Lasf Ifficant conditions could not be determined to determined to determined to determined to determined to determined to determined to determined to determined to determined to determine to determine to determined to determine to deter	b	Due to (c Due to (c) Due to (c) Due to (c) Due to (c) Ath but not res finjury of injury - At h g, etc. (Specio	or as a consequence or as	e of): e of): ying cause g 28c. Injuty actory, office	26. Place of Dother: 4 Nursing any at on? Yes 2 No	23b. Dld 1	tobacco usacco Yes 2 No san autopsy ormed? Yes 2 No one) idence 6 Ott how injury occur (Street and Numi wn, State)	3 ☐ Proid 24b. We ever cool of 1 ☐ her (Specification of Flura anner as sand due to 1)	onset and Death I day ! The cause of death? bably 4 Unknown ere autopsy findings eliable prior fo impletion of cause death? Yes 2 No No No No No No No No No No	
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State of Maryland / Department of Health and Mental Hygiene ?

						Ce	rtificat	e of	Death		R	eg. No.			
Db.			1. Decedent's Name (First, Middle, Lo						100		2. Date of Dea Month	-	Veer	3. Time o	of Deeth
	/sicia ledic		Thelma I.	Hamme	rsla						4	19	98	1:35	AM
	amin		4a. Fecility Name (If not institution, gi	Bay View		Ce	nter		But H		cation of Deeth	4c. County Balti		City	
Fune Direc				Sex 1 □ M 2 0 F	ge (In yrs. lest i	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey 2 9	Year) 32		lece (Stete try) imore	
land wo	12		10a. State 10b. County		10c. City, To	wn or Lo	ocation						1	Od. Inside C	City Limits
Mary	Tiest I	tor	Md. Balti	imore		Dur	ndalk							1 ☐ Yes	2 N
th the	S D C	Director	10e. Street end Number	1.00			10f. Zip	Code			1	Og. Citizen of	What Coun	fry?	
th wi	1		66 Avalon Ave	•				2	1222				USA		
72 hours after death with the Maryland "naturel", or Hema 23e or 28a-f show	Examiner III	by Funeral	11. Marital Status 1 Never Married	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?		Was Decad If Yes, sped 1 ☐ Yes		lispanic Orl an, Mexical Specify:		cify Yes or No- Rican, etc.)		ea - Americ ck, White,		<u>.</u>
d within 72 hours af giena. rr than "naturel", or	No.	Completed	15. Decedent's E	ducation	16	a. Dece	dent's Usua	al Occup	ation	t of workin	100	16b. Kind of B	usiness/ind	dustry	
	No.	nple	Elementery/Secondery (0-12)	College (1-4or	5+)	life.			during mos	it of works	'y	0			
e filed within al Hygiena. other than	E I		17. Father's Name (First, Middle, Les.	41			House	ewii			(F) 4 44:44		Home		
2 E D	_	Be								ne (First, Middle, Maiden Surneme)					
should band Menta	traumatic	ဥ	Charles Turn 19a. Informant's Name/Relationship	4	No Mailie	na Address	/Stroot		Your		umber, City or Town, State, Zip Code)				
d 2 shoth and 17 is m	Tage .										Number, City or Town, Stete, Zip Code) MA 21222				
s 1 end 2 of Health Item 27	other		Mr. Thomas F. Har 20a. Method of Disposition	20b. Placa	of Dispo	valon osition (Ner	ne of		TLTIIN		ce, Md. 21222 Date 20c. Location - City or Town, State				
0 = 2	5		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			netory or o		•	4/	22/98					
permit. Peges 1 er Depertment of Hea Important: If Item 2	once.	1	21. Signefure of Funeral Service Lice		1111	22	2. Name ar	nd Addre	ss of Facili	ty	22/98 Reisterstown, Md, 11824 Reisterstown Road				
		+	23a. Pert1. Enter the disease, or con	nplications that cause	d the death. D	ELINE FUNERAL HOME Reisterstown, No not enter the mode of dying, such as cardiac or respiratory arrest,						rici.	d. 21136 Approximete Interval Between		
Physici /Medic Examir	cal ner	Jer	Immediate Cause (Final disease or condition resulting in death)	e. Left	hemi Sp Due to (or as			utr	a Cev	ebra	l hem	ovrhag	c	14 ha	
the death certificate be executed by the ettending physician and ached for use as the burial-transit	חס פר	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b			consequence of):								
that the death certificated by the ettending phediached for use as the	ed for usi	clan	Part II. Other eignificant conditions	contributing to death t	out not resulting	In the u	inderlying c	ause giv	en In Part I	l.	23b. Did to	obacco use co	ntribute to	the cause	of death
hat be	oatec										1 🗆 Y	es 2 No	3 Prol	oably 4	Unknov
requires	8 .	Completed by									24e. Was en eutop performed?		eve	b. Were autopsy fi eveilable prior to completion of co of death?	
The law ata has be	BOBO	E 0									1□ Y	es 2 No	10	Yes 2	No
ysicien: The secretarian secretarian director, par	ctor,	Be	25. Was case referred to medical						26. Place	e of Death	(Check only or	10)			
Physicien: this certific		0	examiner? 1 □ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/	Outpatier	nf 3□ D0	Oth Oth	ner: 4 🗆 Nu	ursing Hon	ne 5 🗆 Reside	enca 6 □Oth	er (Specif	y)	
tending leath. or: After the fune	me runera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ary Year) 28b	. Time o Injury	f A	8c. Inju Wo 1 □	yat rk? Yes 2□	No	28d. Describe h				
or At offer of Olrect	ka ui pa	Certifi	3 ☐ Suicide 6 ☐ Could not to determined	286. Placa of In	jury - At home, ic. (Specify)	farm, str	reet, factory	, office		2	8f. Location (S City or Tow		er or Aure	i Houte Nun	n <i>ber,</i>
To the Hospital or Att within 24 hours effer d To the Funeral Direct completely filled in by	oletary fill	edical	29a. Certifier (Check only one) 1 Certifying Pl	nyelclan: To the best miner: On the basis o end manner st	f examination (ge, death end/or in	n occurred vestigation	et the ti	ne, date en pinion, des	nd place, e oth occurre	and due to the c ad et the time, d	ause(s) end m lete and plece,	enner es si and due to	ated. the ceuse(s)
To th To th	Eoo	-	29b. Signature and title of certifier Michael a. 7	Vesterman	M.D.	29c. License number 29d. Date signed (<i>Month, Dey, Year</i>) 4/19/98									
V)		30. Name and address of person who Michael L. Wes	completed cause of a	death (Item 23s										
	Stat	e	31. Date filed (Month, Day, Yeer)	32. Regist	grand Jan	idson	Mande	82		-1					



State of Maryland / D

Department of Health and Me	ntal Hygiene 🗎	2	8	5	8
Certificate of Death	20	loo	U	U	0
Certificate of Death	Reg. No.				

RANDALLSTOWN

Physician /Medical Examiner

Directo

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2. Data of Death Month APRIL

8. Data of Birth (Month, Day, Yaar)

DEC. 20, 1918

3. Tima of Death

BALTIMORE

10d. Insida City Limits

1 Yas 2 No

Birthplaca (Stata or Foraign Country)

WHITE

ROMANIA

7:55AM

Yaar

8.8

17

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

ISRAEL

14. Raca - Amarican Indian, Black, Whita, atc.

Funeral Director

the Maryland Items 23s or 28s-f show iner mast be notified at with permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28 any Injury or other traumatic event, the Medical Expressions.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

P

Certification:

Medical

buriel-transit end physician the signed by the e peeu After death. To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi

O. Box 68760

Records,

Division of Vital

State Registrar

1. Decadant's Name (First, Middla, Last) MALKA HERSHKOVITZ 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITAL CENTER NORTHWEST 7. Aga (In yrs. last birthday)
Yrs.

If Undar 1 Year | If Undar 24 Hrs.
Months | Days | Hours | Min. 5. Sociel Sacurity Number 10 M 20 F Yrs. 212-88-1204 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location MARYLAND N/A BALTIMORE 10e. Street and Numbar 10f. Zip Coda 2500 W. BELVEDERE AVE., APT. 808 21215 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Never Marriad 2 Married 1 Yas 2 No 1 ☐ Yas 2 ☐ No Spacify: X□ Widowad 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grada completed) Elemantary/Secondery (0-12) College (1-4or 5+) **HOMEMAKER** 17. Father's Nama (First, Middla, Last) **ABRAHAM** POLLACK 19a. Informant's Neme/Ralationship (Type, Print) AVI HERSHKOVITZ (SON) 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cremetory or other place) 1

✓ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stete 4 Donation 5 Othar (Spacify) BETH TFILOH 21. Signatura of Funeral Sarvica Licansaa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Finel SEPSIS diseesa or condition resulting in deeth)

OWN HOME 18. Mothar's Nama (First, Middle, Maiden Sumame) RACHEL FRUCHTER 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, Steta, Zip Coda) OWINGS MILLS, MD 21117
Data 20c. Location - City or Town, Stata 4 CLIFFDWELLER CT. 4/19/98 BALTIMORE, MD 22. Nama and Addrass of Facility
SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 Approximata Intarval Between Onsat and Deeth 3 DA/S Due to (or as a consequanca of). Due to (or as e consaguança of)

Sequantially list conditions, if any, laading to Immediata causa. Entar Undarlying Cause (Disaesa or injury that initiated avants rasulting In daath) Last Dua to (or as a consequenca of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE DEMIENTIA

23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings aveilable prior to complation of cause of daath? 24a. Wes an autopsy parformed?

25. Was casa rafarrad to medical axaminer? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

1 Yas 2 No 1 ∏Yes 2 ∏ No 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28c. Injury at Work? 28d. Dascriba how injury occurred 1 ☐ Yas 2 ☐ No

invastigation 2 Accident 6 Could not ba datamined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida

28a. Data of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Cartifying Phyaician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end titla of certifiar K.S.RAO.M.D.

043462

29c. License number

29d. Data signed (Month, Day, Year) APRIL 17

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) K.S. R.Ao. M.O.

HOSPITAL CENTER RANDALLSTOWN.

NORTHWEST 31. Dete filed (Month, Day, Yeer)

1 Yes 2 No

27. Manner of Deeth

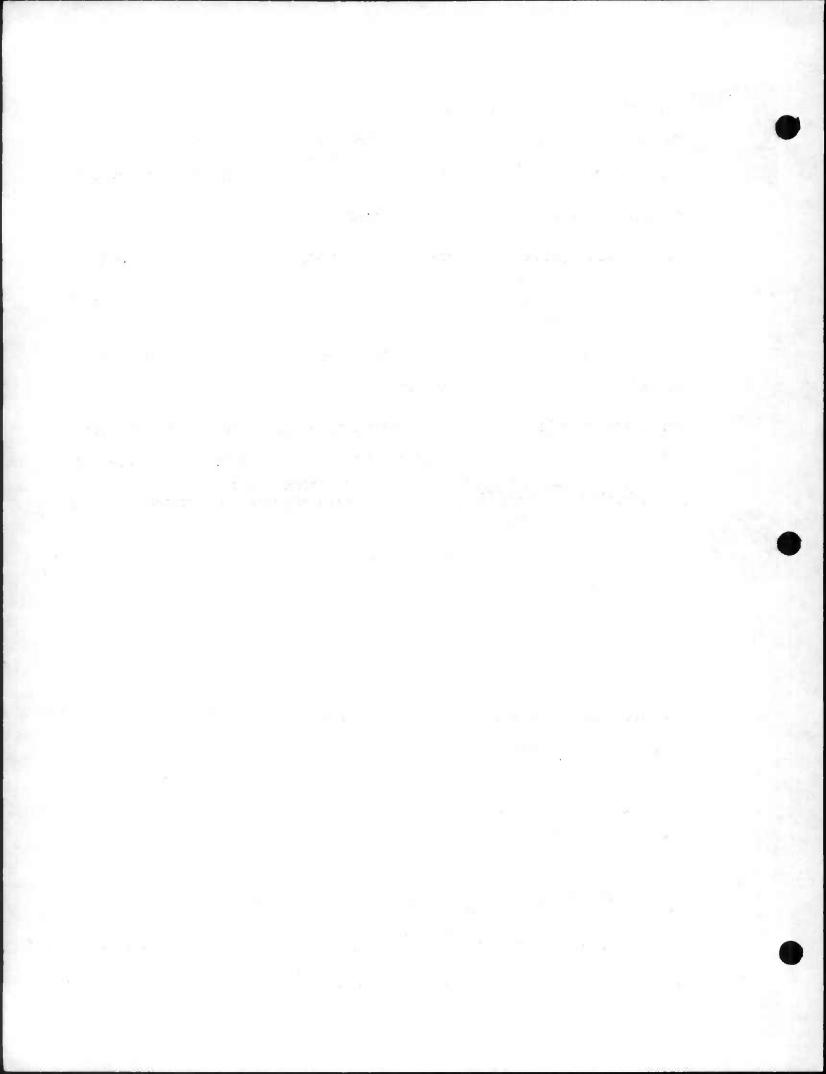
1 Neturel

29a. Cartifiar

APR 23 1998

5 Pending

32. Registrar's Signeture Julia Davidson -Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene r Certificate of Death Item 10, 19b Per FH Film G758 4-23-98 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2 Zelma V. Haynie /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner St. AGNES HOSPITAL If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthdey) 9. Wirthplace (State or Foreign Country) 5. Social Security Numbar **Funeral** 1 □ M 2 🗓 F Days Vrs **Director** 215-09-1246 88 Oct. 17, 1909 Virginia Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number PARKSLEY 10f. Zip Code 10g. Citizen of What Country? 1027 Parksly Avenue 21223 USA Funerai deeth 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours efter 1 ☐ Yas 2 X No If Yes, Give Year or Dates: 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Westinghouse Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembling and Wiring Mfg. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) should be is marked o Samuel Havnie Sadie Abbott 19b. Mailing Address (Steet end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health end Important: If Itam 27 Is m sny Injury or other traum once. Charles M. Haynie, Sr. / Brother 82 Edwars Lane, Reedville, Virginia 22539 20b. Place of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/98 Baltimore, Maryland 4 □ Donation 5 XOther (Specify) Entombment Moreland Mem. Park 22. Name and Address of Facility
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or heart failura. List only one causa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) a Cacute Exacubation of Chronic abstructive Pulmonny disease Examiner Due to (or as a consequence of) 6 days Physician/Medicai Examiner Polumonia attending physician and for use es the buriel-transit The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents Due to (or as a consequence of) Due to (or as a consequenca of): resulting in death) Last 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed anemia cartificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Hnpatient Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 20 No 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural r death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Dey, Year) APR 23 1998 Batimore
32. Registrar's Signature
Full Davidson Pandell

m. D.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

APR:1, 12, 1998

KIM, M.D.

Manyland

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760,

Haynie, Zelma

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98-2207-510

THEODORE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Me	ental Hygiene	20	0	U
Certificate of Death	Reg No			

Reg. No.

3. Time of Death

1:45P.M.

1 Yes 2 No

Approximate Intarvai Batween Onsel and Death

29d. Date signed (Month, Dey, Year)

APRIL 22,1998

111 Penn Street, Baltimore, Maryland 21201

ISZKIEWICZ **Physician** /Medical Examiner

Funeral Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiene. our and Mental h Jernit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 to marked of ò

Maryland 21215-0020

Baltimore,

Physician /Medical Examiner

certificate be executed

Box 68760

P.0.

Division of Vital or Attending Physician: physician and the burial-trans 88 USB S ò signed by the a d be detached f should page 2 director Be 10 funeral Certification:

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has

certificate

this

After

after death. Director: Aft

To the To the F

filled in 24 hours Hospital

completely

Medical

10a Stale MD Directo Funeral à Completed Be Examiner Physician/Medical ģ Completed

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Theodore Iszkiewicz A. APRIL 21,1998 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death 3523 WOODSTOCK AVE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10XM 2□ F Months Days Hours 214-50-2162 49 Yrs. Aug 9, 1948 MD Usuai Residanca of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21213 USA 3523 Woodstock Ave 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 4 Home Products Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Stanley Iszkiewicz Helen Scztinska 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informani's Name/Relationship (Type, Print) Stanley G. Iszkiewicz Edgewood, MD 21040 711 Rainbow Ct. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Slate 22 1 ☐ Buriel 2 XCremation 3 ☐ Removal from State 1998 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD Metro Crematory 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 21 Signeture of Funeral Service Licensee olt Sollers Point Rd 7110 23a. Part | Enter the des Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finel ATHOROSCOPHOTE CAMO 101 AScurre DISTANT disease or condition rasulting in daath) Due to (or as a consaquance of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? PARTIAL 1 Yes 2 No 1 Yes 2□ No 25. Was casa referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1X Yes 2 No 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural Injury 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

State Registrar

2

MARYARIOR 31. Date filed (Mohth, Day, Year)

APR 23 1998

29b. Signature and title of cartifier

Minte

29a. Certifier

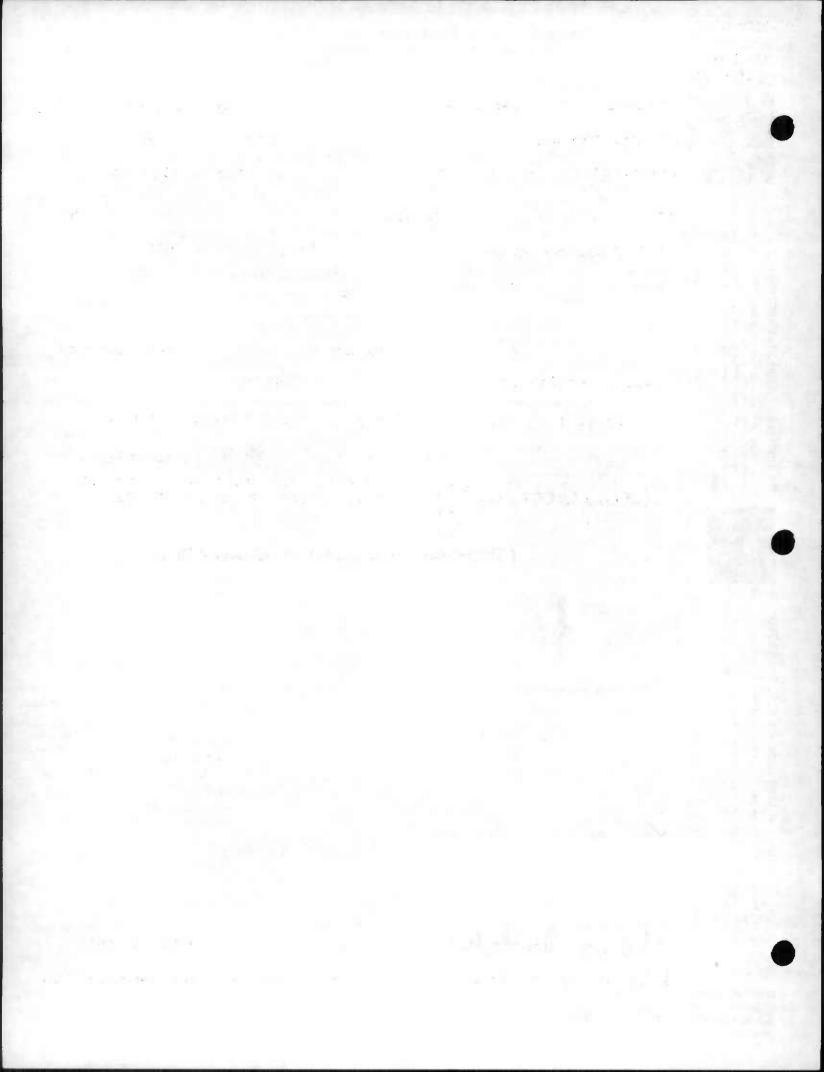
(Check only one)

Koper 32 Pagintrar's Signature

wo

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95



ALBERT **JOHNSON**

State of Maryland / Department of Health and Mental Hygiene Items: 23 part I,27,28a-f per MEO G-758 4/29 Certificate of Death

0	0	(- 1
6	0	6	

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

2. Date of Deeth APRIL 18, 1998 3. Time of Death 10:36 PM.

10d. Inside City Limits

Approximete Intervel Between Onset and Death

1 Yes 2□ No

Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

APRIL 19, 1998

1 TYes 2 □ No

Funeral

Director with the Merylend

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours efter death thygiena.

is marked other permit. Pegas 1 end 2 should be in Department of Health end Mental important: If Item 27 is marked or any injury or other treumatic ever

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

physician and the bunal-transit 88 USB jo by the a 2 been si has irector, page 2 director, After this funeral r death. l Director: A 24 hours efter on Funeral Direction Property filled in by

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

ALBERT SON ohn 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) **JOHNS** HOPKINS HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-66-9833 180 M 2□ F Yrs. 11-22-56 MAY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMOVE N Directo Md-10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Apt. 5+. 302 21213 5.17 1516 E. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bieck, White, etc. 1 ☐ Yes 2 ☐ No 1 Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify Specify: If Yes, Give Yeer or Dates à BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Beer Elementary/Secondary (0-12) College (1-4or 5+) HEL Bubwiesger Der 10 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be A EARL Johnson GRE 10 NIAN 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City of Town, Stete, Zip Code) 1615 ChASE Mother E 5%. VIVIAN JOHN SON BALto. Md. 2/213 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition 1 W Buriel 2 Cremation 3 Removal from State 25/98 4 ☐ Donation 5 ☐ Other (Specify) Voschell CEMETER BALTO, md 21. Signeture of Funeral Service Licenses Broadway BA Ho, Md. 21213 Miller 23a. Perfi. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. P.C. FUNERAL Home I SERVICE Immediate Cause (Final disease or condition resulting In deeth) ALCOHOL AND NARCOTIC INTOXICATION Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Physiclan/Medical Due to (or es e consequenca of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed 1XYes 2□ No 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 🗡 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1XXYes 2□ No 2 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work?

Unknown

28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

State Registrar

completely

To the I within 2

Certification:

1 Neturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifie

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Radentz 111 Penn Street, Baltimore, Maryland 21201

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated.

29c. License number

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 No

O.C.M.E.

Unknown

Unknown

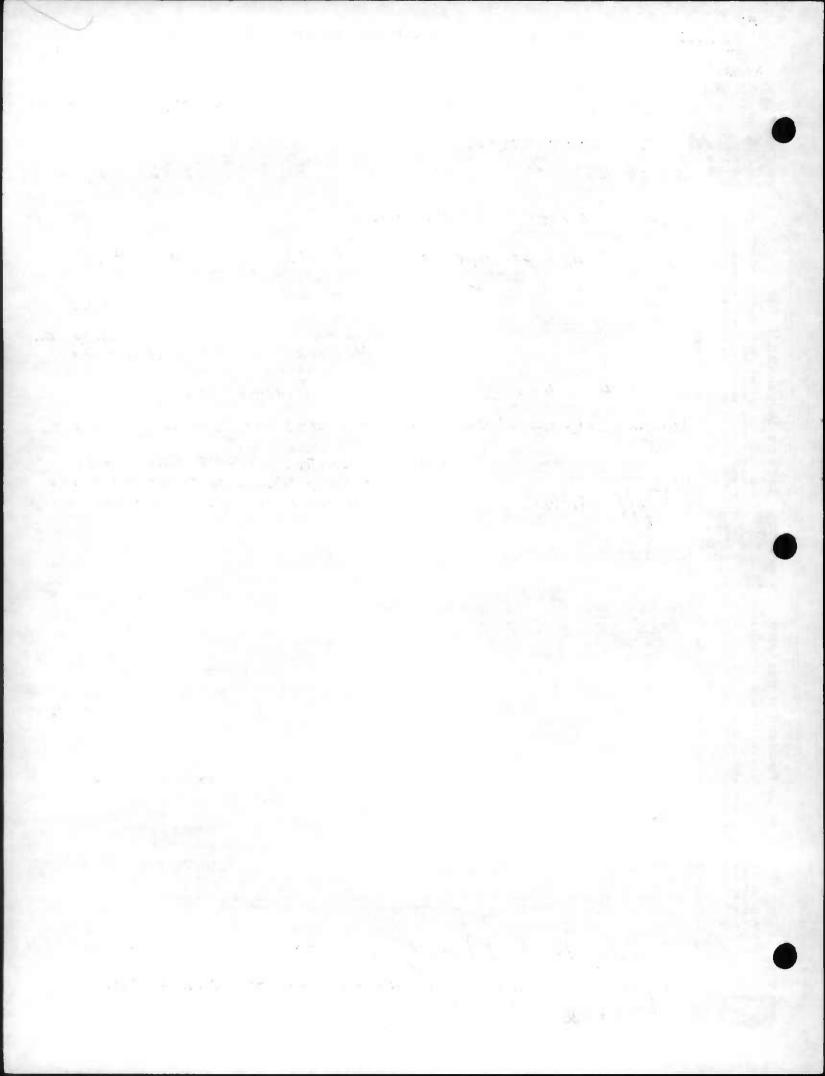
ohrn Registrar's Signature

Unknown

Unknown

5 Pending Investigation

6 Could not be



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Bernard F. King 19, 1998 April 7:25 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner VA Maryland Health Care System N/ 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | 6 (Mootb, Day, Year) BALTIMORE 5. Social Security Number 6. Sex/ 1 M 2 □ F 9. Birthplece (Stete or Foreign **Funeral** MARYLAND 217-26-6899 Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show theiry or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 700 S. GLOVER STREET 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: KOREA Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 YEARS TRUCK DRIVER KAT Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) GEORGE KING MARY RHEA 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MRS. BERNADETTE KING 700 S. GLOVER STREET BALTO. MD. 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ABurlal 2 Cremetion 3 Removel from Stete GARDENS OF FAITH 4-23 BALTO. CO. MD. 4 ☐ Donetion 5 ☐ Other (Specify) ture of Funeral Service License RACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 Pert1. Enter the disease, or commicetion, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause of each line. Approximate intervel Between Onset and Deeth Physician /Medical immediate Cause (Final disease or condition resulting in death) _e Sepsis 24 Hrs. Examiner Due to (or as e consequence of) 3 days Renal Failure physician end the buriel-transit that the death certificate be executed Exam Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): for use es ed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobecco use contribute to the cause of death? S/P Cardiac Transplant 1 ☐ Yes 2 ☐ No 3 Probably 4₽ Onknown been signed t should be det Records, þ The law requires 24b. Were eutopsy findings evellable prior to Completed 24a. Was en eutopsy completion of cause of deeth? certificate has lirector, page 2 s 1 Yes 20 No 1 Yes 2 No sion of Vital e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifical letely littled in by the funeral director, I 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) exeminer? Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Dinpatient 2 ER/Outpetient 3 DOA Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier To the within 2 To the I complet 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed ceuse of deeth (tem 23a) (Type, Print) Shelia B. Dunaway, M.D., 10 N. Greene Street, Baltimore, MD 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State APR cha Tainds Registrar

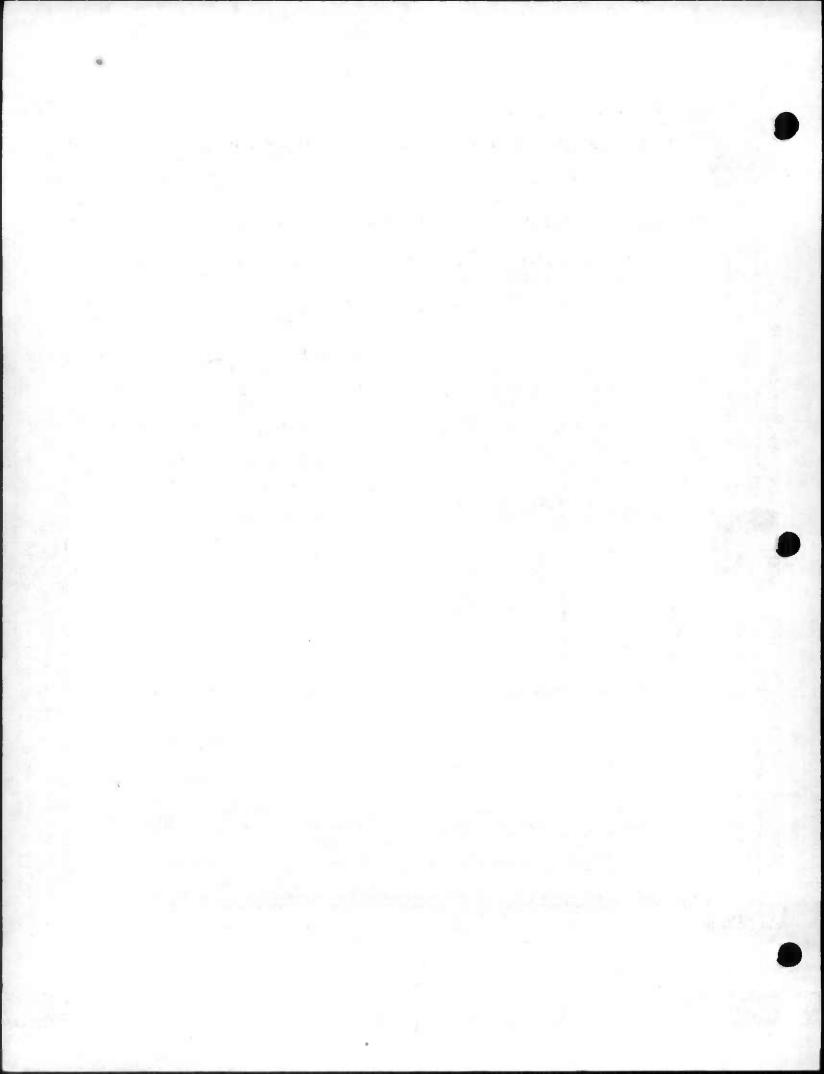
Bodies

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month William Alexander 1998 9:45 Am Apri /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of B South Kenwood Avenue 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-01-8807 Usual Residence of Decedent 120M 2□ F Days Hours Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 10Xyes 2□No Baltimore Director Ma 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 238 2122 Kenwood Ave. U.S. should be filed within 72 hours efter death and Mentel Hygiene. marked other than "natural", or items 23. Funeral Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Amed Forces of 1 Mayes 2 No If Yes, Give Year or Dates: 44-46 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No by Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Company Chemical permit. Peges 1 and 2 should be file Department of Health end Mentel Hy, Important: If flem 27 is marked other any injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cummins Lasper Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Wife South Ken wood Avenue atherine Balto. Md. 21224 Lona 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1- Burial 2 □ Cremation 3 □ Removal from State 4/22/98 Balto. Md Oak hown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility S. Zeiler & Son, Inc. Charles 6224 Eastern Avenue Balto Md. 21224 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Pulmonary Disease The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buna P.O. Box 68760, Due to (or as a consequence of) 98 ate has been signed by the e page 2 should be detached to Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown he.imer Division of Vital Records. þ Be Completed 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Tes 1 Yes 2 No "Hispital or Attending Physician: " 25 Dours after death. Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To In by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physicien: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and manner stated. 29a. Certifier E 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SilverDo 3411 Balto. Md Bank 31. Date filed (Month, Day, Year) APR 2 3 1998 32. Registrar's Signature State Aria Davidson Randelle

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené) 864 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 35 am 1998 PULSO DG JAMES LORRISON 20, /Medical 4b. CitynTown, or Location of Deeth 4a Facility Neme (If not institution, give street end number) Examiner A Uare NKIM 5. Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys OM M 2□ F Months Hours 9173 Director 234 40 Usuel Residence of Decedent 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits 1 Yes 2 No Director CARMARO BALTIMORS 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? must be r 8833 Avonoals 15000 21334 D.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status the Medical Examiner Yes 2 No Yes, Give 1 Never Married 2 Married ò 1 Yes 2 No Specify: ETTHW à 3 Widowed 4 Divorced Yeer or Detes: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) 127RS BULL ATLANTIC CENTRAL OFFICE ISCH. T is merited other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 8 GILFILEN JAMES W. 10RRISON Pages 1 and 2 should LECAH 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) PARKVILL MARYANO ABOLL
Date 20c. Location - City or Town, Stete Health Item 27 CIDRED E.I 8833 AVONDAL 1088800 altimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition HORIZA 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) CAPTANISATTON 148 CATTIONORE 22. Name and Address of Fecility
EVANS FURRAL CHAPIL — BIRR 21. Signature of Funeral Service Lice 3 DEWART DRIVE FORST HILL MALYSAM 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) **Examiner** Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es a consequenca of): that the death certificate be exec P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending physical for use as t signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en eutopsy Completed page 2 s 2DNO 1 Yes 2 No 1 Yes certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To this funerai 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Deleturel 5 Pending n 24 hours after death.

Funeral Director: Afte bietely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ò 29e. Certifier (Check only one) 115 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the ceuse(s) end menner stated. Medical To the Hosp within 24 hor To the Fune completely fi 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 28211 Cesari Mo

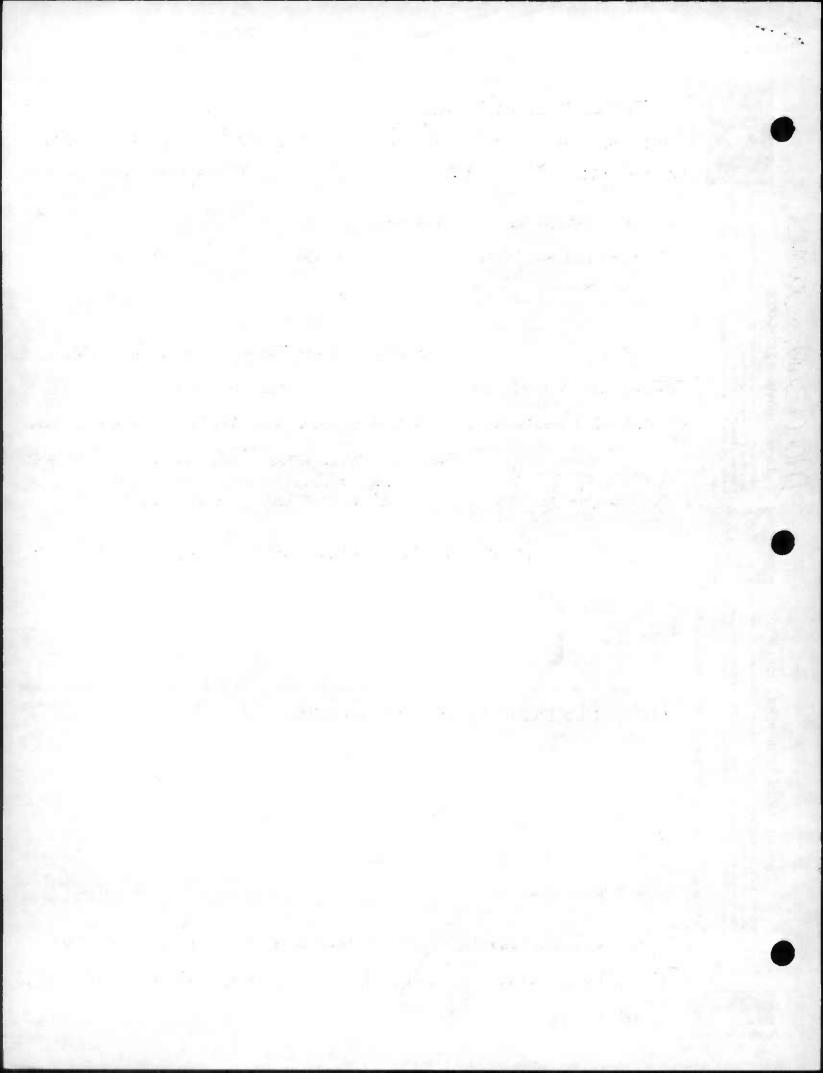
State Registrar

APR 23 1998

31. Dete filed (Month, Dey, Year)

32, Registrer's Signature

end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

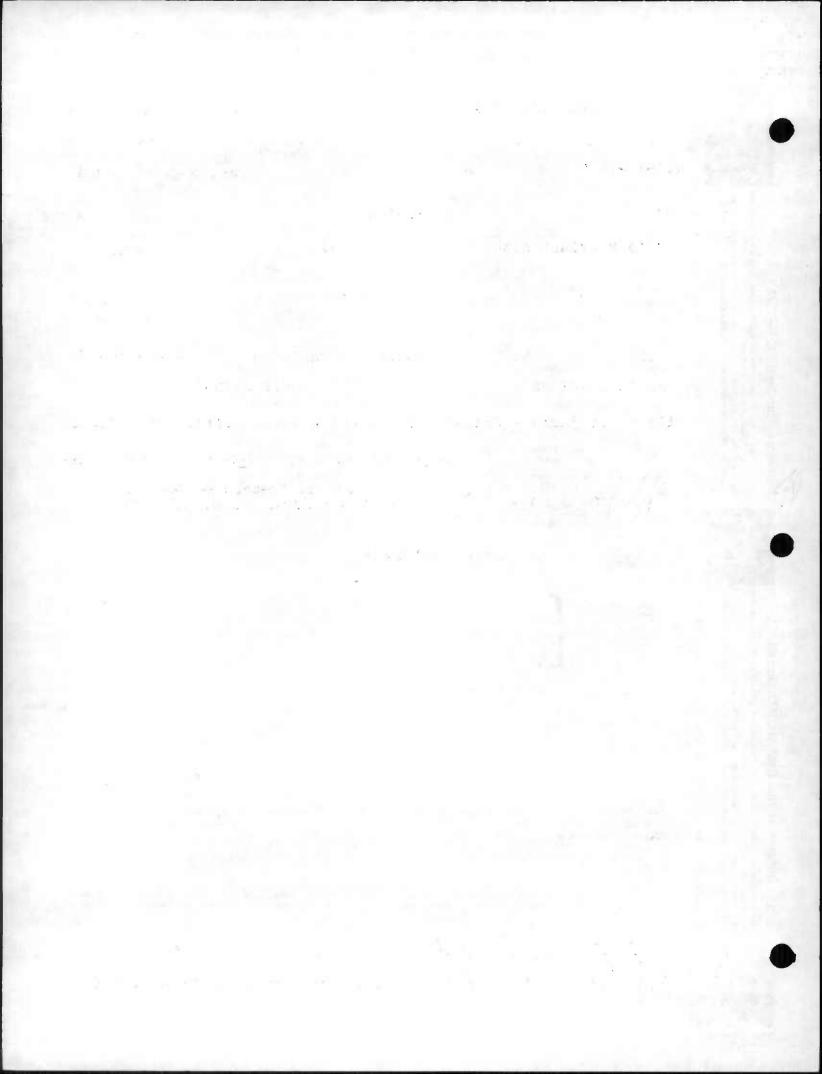


98-2069-510 jhm BENZE MUN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 2 8 6 5

NKEMENA			,	Certificate (of Death		Reg. No.	
	1. Decedent's Nama (First, Middla,	Last)				2. Date of Da Month		3. Tima of Death
Physician /Medical		MUNKEMENA				APRIL	•	02.00 78
Examiner	An English Name //f ant inctitution	giva straat and numbe	r)		4b. City, Town, o	or Location of Deeth	12 199 4c. County	of Death
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Funeral Director	010-80-3885		Aga (In yrs. lest l 48	oirthday) If Undar 1 Y Yrs. Months Da	agr If Under 24 H	n. (Month, Da	th ly, Year) 2 1950	Birthplaca (Stata or Foraig Country) ZAIRE
Pu *	Usual Rasidanca of Dacedent 10a. Stata 10b. County		10c. City. To	wn or Location				10d. fnsida City Limit
the Maryland 28a-f show Doutled at	MD 377			IMORE				1X Yes 2 N
vith the or 28a be notified		ND AVENUE		10f. Zip Co 212	da 218		10g. Citizen of T	Whet Country?
ter des		12. Was Dacedar Armed Forcas d 1 Yes 2 If Yas, Giva Year or Datas	3?] No	13. Wes Decedant If Yas, specify (of Hispanic Origin? Cuben, Maxican, Pu No Specify:	(Specify Yes or No arto Rican, atc.)	14. Rac Bla Specif	ce - Amarican Indian, ck, Whita, alc.
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21215-0 ed within 72 ho ygiene. wr than "naturi ft, the Medical	(Specify only highest Elementary/Secondary (0-12)	grada complated) Collaga (1-4o		(Giva kind of work di life. DO NOT use re	ona during most of w	vorking		
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Aar 2 shot and Is m	19a. Informant's Name/Ralationsh			b. Mailing Addrass (St				, State, Zip Code)
ここのと	William Benja: 20a. Mathod of Disposition	min - Fri		306-C Led		Balto	., Md.	21239 - City or Town, Stata
	1 Burial 2 Cramation		e cema	tary, cramatory or othar	plece)			
Baltimo	4 Donation 5 Other (Sp.		Sap	en II Cem	-	5-2-98	Lumbumas	shi, Zaire
Baltin permit. P Departmi Importan any Injur pfice.	21. Senature of Funeral Service L	Censee A	Mis	Wm. C. M	ddrass of Facility larch_Fune			
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/Medical Examiner	Immediata Causa (Final disaase or condition	, Card	iac arr	hythmia				
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f Vital Re ystelen: The last certificate he director, page	25. Was cese refarred to medical				26. Placa of E	eath (Chack only	one)	
of Vital Physician: T this certificat ral director, pr		Hospital: 1 ☐ Inpa	tiant 2 ER/0	Dutpatient 3 DOA	Othar: 4 Nursing	Homa 5 ∏ Rasi	dance 8 Oth	har (Specify)
Vision of Attending Phar death. Sector: After this by the funeral of the funeral		28a. Data of In (Month, E	jury 28b		fnjury at Work? 1 □ Yas 2 □ No	28d. Dascribe	how Injury occur	rred
Division of standing P is after death. and Director: After to death in by the funera	3 Suicida 6 Could n. 4 Homicide determin	ed 286. Place of I	njury - At homa, atc. (Specify)	farm, straet, factory, of	fice	28f. Location (City or To	Straat and Num wn, Stata)	ber or Rural Route Number,
Division or To the Heaptial or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Cartifiar (Check only one) 1 Certifying 2 Medicaf E	Physician: To the best saminar: On the basis and mannar	of axamination a	ga, daath occurred at the and/or investigation, in i	na Iima, data end ple my opinion, daath oo	ce, and dua to tha courred et tha tima,	ceuse(s) and m data and place,	annar as stated. and dua to the cause(s)
To the Comp		10	. ^	29c. Li	canse number		29d. Date signe	ed (Month, Dey, Year)
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15	30. Name and addition of person w	ho complated ceuse of	AA ()	(Typa, Print)	meet Ral	timore !		
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State Registrar

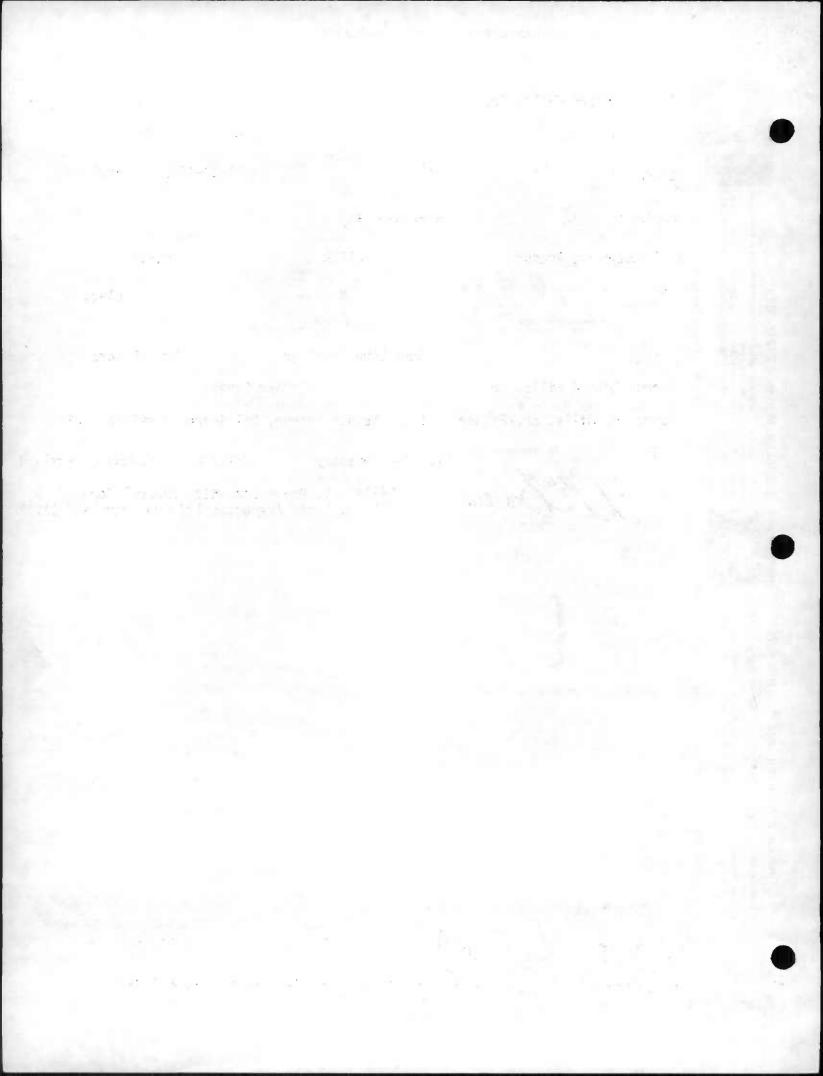


WRC 98-2065-510 GEORGE E. MILL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 12866

			Items: 23 part I, 2		758 4	/24/98	Certifica	te of	Death	2. Date of Dea	Reg. No.	i	3. Time of Death
	Physicia		George Edward Mi							Month	11, 199	Year 8	8:40 PM.
j.	/Medic Examin		4a Facility Name (If not institution, gi		or)				4b. City, Town,	or Location of Death			
	Funeral Director		217-68-5274	Sex 100 M 2□ F	Age (In yr	rs. last birt	Months	Days		in. 8. Date of Birth (Month, Day 12-27-	1957	9. Birthp Coun Mary	lace (State or Foreign try) Land
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Towr	or Location					1	0d. Inside City Limits
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	with with	ā	5006 Pembridge Av	00110				1215					m y r
	ms 2;	era	11. Maritai Status	12. Was Deceder	nt Ever in	U,S.			tispanic Origin?	(Specify Yes or No- erto Rican, etc.)	U.S./	ca - Americ	
2-0050	urs a	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force: 1 Yes 2 If Yes, Give Year or Dates] No				Specify:	erto Hican, etc.)		ck, White,	
Ç C	72 hc	eted	15. Decedent's E			16a.	Decedent's Usu (Give kind of w	ork done	during most of t	working	16b. Kind of B	usiness/Ind	dustry
בער	filed within Hygiena. ther than	Completed	Elemantary/Secondary (0-12)	College (1-4o	r 5+)	11	life. DO NOT	ise retire	d)				
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tand	should be nd Mental marked o	o Be	George Edward Mi	•						Savage			
Mary	and M series	-	19a. Informant's Name/Relationship	(Type, Print)		19b.	Mailing Addras	s (Strae		Rural Route Numbe	r, City or Town	, State, Zip	Code)
7.7	aft 27		George E. Mills,	Sr./Fath						Baltimore	e, Mary	land	21237
Battimore,	-155		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from Stat	20b	. Place of cematar	Disposition (Na y, cramatory or	ma of other pla	ce)	Data	20c. Location	- City or To	wn, State
	permit. Pages Department of Important: If its any Injury or o		4 Donation 5 Other (Special Service Acceptations of Fundamental Se	(h)	M	t. Z	ion Cem		y ess of Facility	4/18/98	Lands	downe	, Haryland
68/60,	ficate be physicials to the bur	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Undartying Cause (Disease or Injury that initiated events resulting in death) Last	ARTERIOSC a. c.	LEROT Due to	IC CAL		LAR D		an u corpirady a	timore,	Mary	Landma-1217 interval Between Onsat and Death
200	attendin for use	Physician/M											
9	uiras that the de	hysi	Part II. Other eignificant conditions	contributing to death	but not re	esulting In	the underlying	cause gi	ven in Part I.				the cause of death?
7	s that	by P								- "	2010	0	Judy 4 Olikilow
cords,	law requiras that the as been signed by th 2 should be datache	Completed									an autopsy med?	ev.	ere autopsy findings allable prior to mpletion of cause death?
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DIVISION	To the Hospital or Attending Physicien: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not		Day Year)	Ir	М		nyat nrk?]Yas 2∐No	28d. Describe h			
2	tal or At rs aftar al Direct led in by	Certif	4 Homicide detarmined	28e. Place of I building,	atc. (Spa	nome, fai	rm, street, facto	ry, offica		City or Tov	m, State)	Der or Hura	il Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical			of exami					ace, and due to that courred at the time,			
	To the to the to	Σ	29b. Signature and title of certifier	10	11	1	29		se number		29d. Date sign		
)			30. Name and address of person who	completed cause of	death (It	am 23a) (Type, Print)		.C.M.E.		APRIL 1	2, 19	70
		1	J. LAREN !	OCKE,	M			reet	, Balti	more, Mar	yland 2	1201	
	Stat Registra		31. Date filed (Month, Day, Year)	1998 Pagis	Julia	David	son-Rande	100_					



State of Maryland / Department of Health and Mental Hygiene

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5		2	O	O	-

Physician
/Medical
Examiner

Michael F.

Funeral

r 28a-f show

Director

with the Meryland Director 7 is marked other than "natural", or itams 23s or traumatic avent, the Medical Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after death the permit of the filth and Mental Hygiene.
Important: If flem 27 is merked other than "natural", or flame 23 any injury or other traumatic avent, the Mendical Expension main Funeral à Completed Be

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

Physician /Medical Examiner

physician and the buriel-transit requires that the death certificate be executed 98 use i for signed by the a page 2 certificate hes Hospital or Attending Physician: After this funerel 24 hours after deet Funeral Diractor: 6 filled in

Physician/Medical Examiner

b

Completed

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10

Certification:

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Registrar

completely

within 2

Items: 23 part I,27 per MEO G-759 5/7/98 retCertificate of Death 1. Decedent's Neme (First, Middle, Last) McNamara 4e Fecility Neme (If not institution, give street end number) NORTHWEST HOSPITAL 7. Age (In yrs. lest birthday) Months **™** M 2□ F 52Yrs 235-72-3746 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location MD Baltimore Randallstown 10e. Street end Number 9701 Branchleigh Rd. 12. Wes Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Yeer or Detes: 11. Maritel Stetus 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) V.P. Marketing 17. Fether's Neme (First, Middle, Last) Tiberius McNamara 19e. tntorment's Neme/Reletionship (Type, Print) Roberta L. McNamara - wife 20b. Pleca of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition Buriel 2 Cremetion 3 Removal from State St. Johns' Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart tellure. tmmediate Ceuse (Finel disease or condition resulting in deeth) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequenca of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence of):

2. Date of Deeth 3. Time of Deeth APRIL 20, 1998 21:54 PM 4b. City, Town, or Location of Deeth 4c. County of Deeth Randallstown
r it Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Oct 4, 1945 9. Birthplace (State or Foreign W. V. BALTIMORE 9. Birthole If Under 1 Year Deys 10d. Inside City Limits 1 ☐ Yes 2 TNo 10f. Zin Code 10g. Citizen of Whet Country? USA 21133 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Bleck, White, etc. 1 Yes 2X No Specify: Specify: white Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry wholesale 18. Mother's Neme (First, Middle, Meiden Sumeme) Virginia Williams 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9701 Branchleigh Rd. Randallstown, MD 21133 Dete 20c. Location - City or Town, Stete 4/24/98 Ellicott City, MD 22. Name end Address of Fecility 11824 Reisterstown Rd. Reisterstown, MD 21136 Eline Funeral HOme Approximete Intervat Between Onset end Death

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy tindings evailable prior to completion of cause of deeth?

1 Yes 2 □ No 26. Piece of Deeth (Check only one)

Veryes 2 No

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth

1XXNeturel

2 Accident

3 ☐ Suicide

5 Pendina Investigation

28e. Date of Injury (Month, Dey Year) 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of

28c. Injury et Work? 1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d Describe how injury occurred

28e. Pleca of Injury - At home, term, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as stated.

2 Madical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated.

28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MP 30. Name and address of person who completed cause of deeth (tterh 23a) (Type, Print) OCME

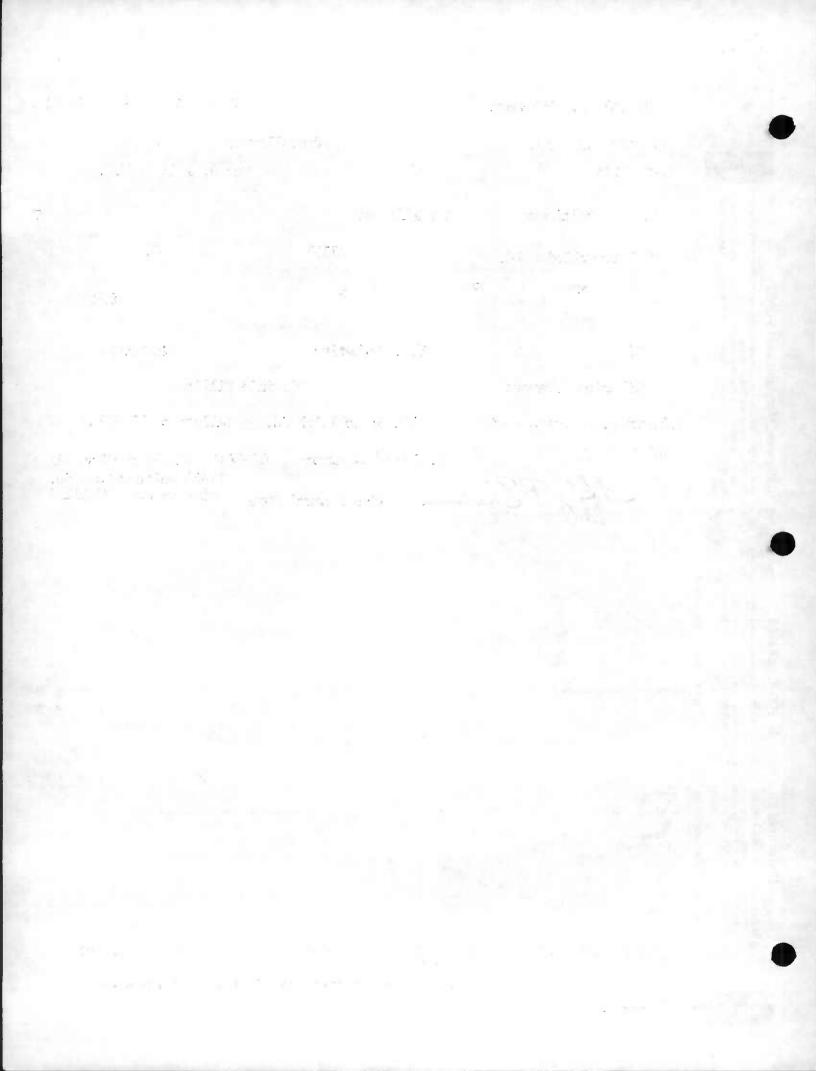
APRIL 21, 1998

111 Penn Street, Baltimore, Maryland 21201

phyn 31. Dete tiled (Month, Dey, Year)

32. Registrer's Signeture Ma Burk

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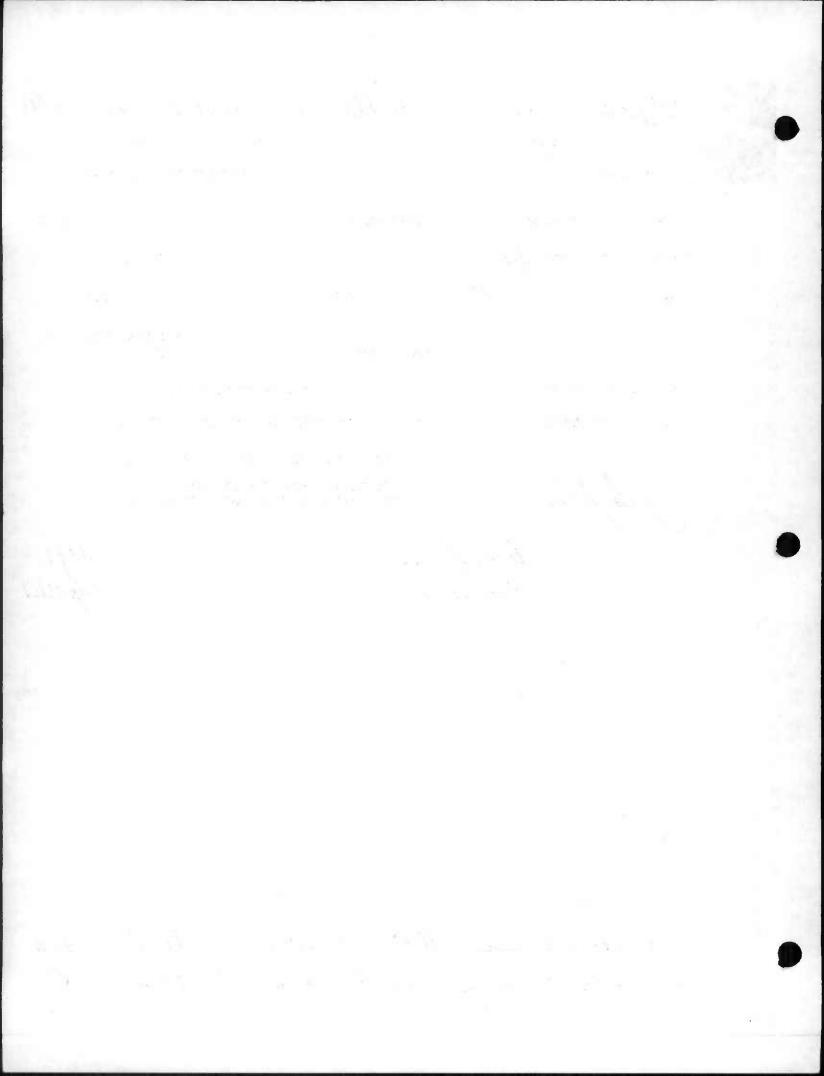
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth dythe Middleton **Physician** pril 11:00 AM 1998 /Medical 4e. Fecilio Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** GOOD SAMARITAN HOSPITAL BALTIMORE 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6 Sex 8. Dete of Birth (Month, Dev. Year) Funeral 1□ M 2X F Months Deys Hours 83 Yrs. Director 213-10-3641 11/14/1914 MARYLAND Usuel Rasidence of Decedent the Maryland 10e Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò items 23a 2320 OLD FREDERICK ROAD U.S.A. daath Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②ONo If Yes, Giva Yeer or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☐No Specify: Specify: WHITE þ XXWidowed 4 □ Divorced "naturel". Completed 15. Decedent's Education 16e. Dacadant's Usual Occupetion 16b. Kind of Business/Industry (Specify only highast grade completed) (Give kind of work done during most of working life. DO NOT use retired) FAMILY & CHILDRENS Hygiane. Elemantary/Secondery (0-12) College (1-4or 5+) 12 SERVICES d 2 should be filed w h and Mantal Hygian is marked other th SECRETARY 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be JOHN GEORGE GRAEF CARRIE VIRGINIA BUTTS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pagas 1 end 2: Depertment of Health at Important: If Item 27 is eny Injury or other treu LYN MIDDLETON/DAUGHTER 2320 OLD FREDERICK ROAD CATONSVILLE, MD 21228 20b. Plece of Disposition (Nema of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) MEADOW BRANCH CEMETERY 4/25/98 WESTMINSTER, MD 22 Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, failure. List only ona cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting In deeth) **Examiner** Examiner homa Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaasa or injury that initieted evants rasulting in daeth) Lest and Due to (or es e consequenca of): P.O. Box 68760, physician The lew requires that the death certificate be-Physician/Medical the Due to (or es e consequença of): for use es ed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 ☐ Probably 4 ☑ Unknown 1 Tyes 2 No Records, py 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes en eutopsy peen completion of cause of deeth? pege 2 1 ☐ Yes 2 ☑ No 1 ☐ Yas 2 1 No cartificata Division of Vital To the Mospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, it Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accidant 3 Sulcide 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicida Medical 1 Certifying Phyelclan: To the best of my knowladga, daath occurred at the time, date end pleca, end due to the cause(s) end mannar es statad.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daath occurred et tha tima, date and pleca, end due to the ceuse(s) and menner stated. 29a. Cartifier 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number dress of parson who completed causa of daeth (Itam 23a) (Type, Print) 560/ Lock Ravere Blud, Baltimore, 17D, 2)206 U Year) Registrar's Signature 32. State Ca Davidson Registrar

DHMH 16 Rev 6/95



98-2153-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

MONTEZ MATHEWS State of Maryland / Department of Health and Mental Hygiene

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		- 1	/IVI	edi	ica

Items: 23 part I,27 per MEO G-758 4/29/98 recrificate of Death 1. Decedent's Name (First, Middle, Last)

2. Date of Death

Physician	
/Medical	
Examiner	

MATThews MONTEZ 4a Facility Name (If not institution, giva street and number)

102M 20 F

Month APRIL 3. Time of Death

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

17,1998 12:40P.M. 4c. County of Death

Funeral Director

213-86-5139 Usual Rasidance of Decedent 10b. County 7. Age (In yrs. last birthday) If Under 1 Year Months Days 25 Yrs.

If Under 24 Hrs.

Birthplaca (State or Foraign
Country)

r than "natural", or items 23s or the Medical Examiner must be a

Baffimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygierse, ent. If them 27 is merical other than "r

10a State

Directo

Funeral

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Completed

89

Examiner

Physician/Medical

by

Completed

Certification: To

10c. City, Town or Location 134Lt MOVE 10d. Inside City Limits 1 Tes 2 No

10g. Citizen of What Country?

16b. Kind of Business/Industry

45

10e. Street and Number

5. Social Security Number

1 Navar Marriad 2 Married

12. Was Decedent Evar in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1 □ Yes 2 No Specify:

14. Race - American Indian BLACK

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT usa ratired)

Elamantary/Secondary (0-12)

College (1-4or 5+)

Hogse

MARYLANDClyb 18. Mother's Name (First, Middle, Maiden Surfame)

17. Father's Name (First, Middle, Last)

dwin SISTER 19a. informant's Name/Relationship (Type, Print)

Fitche 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

NISSA 20a. Method of Disposition

3420 ELMOK 20b. Place of Disposition (Name of cemetery, crematory or other place)

AVe. BACto. Und. 21213 Date / 20c. Location - City or Town, State 4/25/98

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

BACTIMORE

21. Signature of Funaral Service Licensee

Miller P.C. Fynengl 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Physician /Medical Examiner

physician end the buriel-transit

88 esn

director.

this

After

death.

24 hours after deat Funeral Director:

To the Hosp within 24 hor To the Fune completely fi

filled in by

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final

disease or condition resulting in death)

DIABETIC KETOACIDOSIS

Due to (or as a consequence of):

Due to (or es e consequence of):

Dua to (or as a consequence of)

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last

art II.	Other significant	conditions	contributing to	o death	but not	resulting in th	e underlying	ceuse g	iven l	in Parl

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Tes 2 No

28d. Describe how injury occurred

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 THES 2 No

25. Wes cese referred to medical exeminer? TXXYes 2□ No 27. Manner of Death

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Straet and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Sulcide

4 - Homlcide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

APRIL 18,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

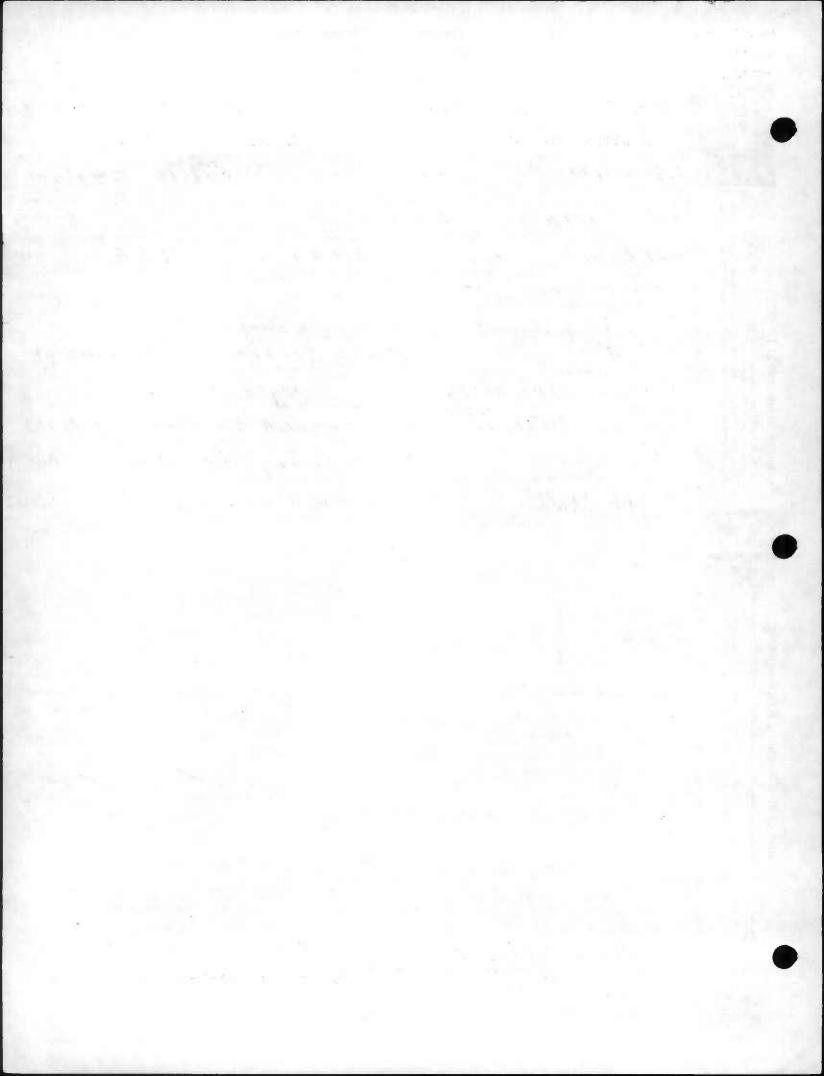
hute no Dennis

111 Penn Street, Baltimore, Maryland 21201

State Registrar

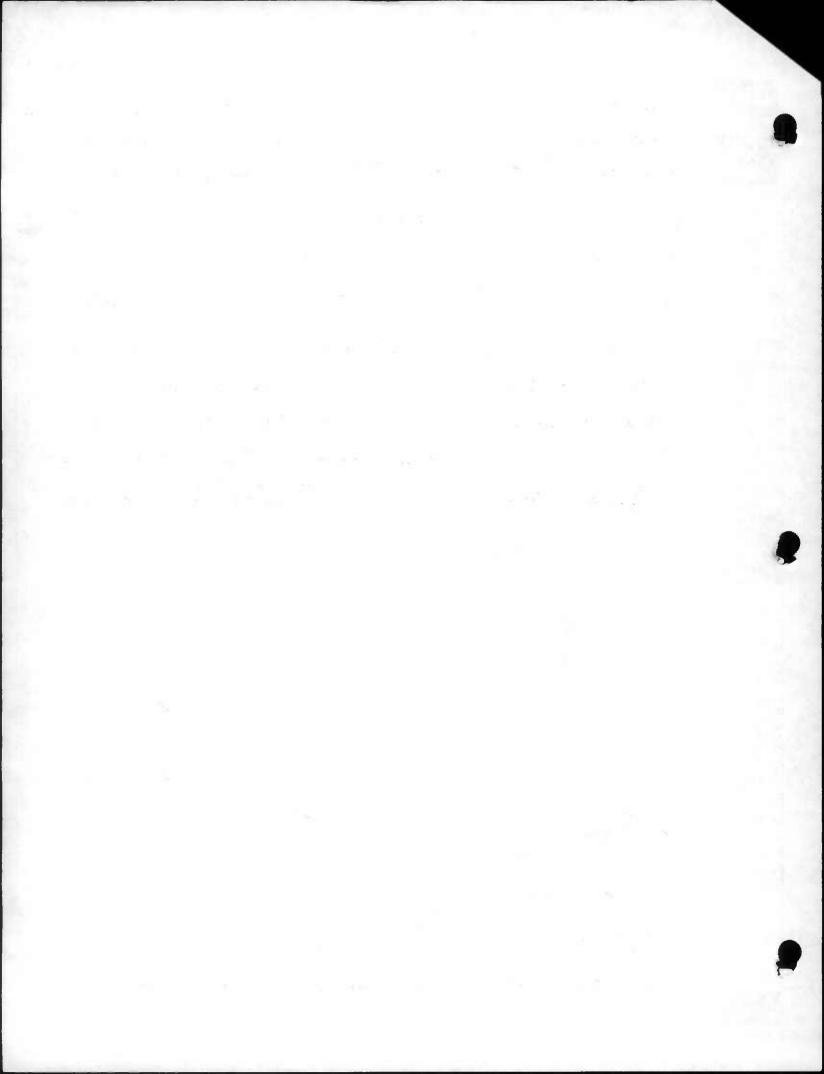
APR 2 4 1998 31. Date filed

32. Registrar's Signature har Davidner



State of Maryland / Department of Health and Mental Hygiene

						C	ertifica	te of	Death			Reg. No.	8 1	20	10
	Physici	an	Decedent's Neme (First, Middle, Last)								2. Date of De Month	ath Day	Yeer	3. T	ime of Death
U	/Medi		Esther Nolan								April	20	1998	3:	40 a.m.
	Examir		4e. Facility Name (If not institution, give	street and number)					4b. City, To	wn, or L	ocation of Deeth	4c. C	ounty of Dea		
7			Stella Mans							וחסחו			BAlti	more	
,	Funerai Director		5. Social Security Number 6. Security Number 1 Security Number 6. Security Number 1 Security Number 6. Security Number 1	7. Age	(In yrs. las		Months	Deys	if Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De March 31	y, rear)		thplace (Sountry)	State or Foreign
	Pue M		10e. State 10b. County		10c. City,	Fown or I	Location							10d. Ins	side City Limits
	dery f sh	5	Maryland			FALL	IMORE								Yes 2 No
	the 28s	Director	10e. Street end Number					ip Code				10a Citize	on of What Co	nuntry?	
	3a or		3725 Cedar Drive						21207			rog. Omzo	USA	Juliu y 1	
	ms 2	Funeral		12. Was Decedent E	ver in U,S.	13	. Was Dece			igin? (Sp	ecify Yes or No	- 14	. Race - Ame	erican Ind	ien,
Maryland 21215-0020	a within 72 hours efter death with the Merylend jiene. r then "natural", or items 23a or 28a-f show the Medical Example must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		If Yes, spo				ecify Yes or No Rican, etc.)		Black, Whit	hite	
2	2 ho	Completed	15. Decedent's Edu			16a. Dec	edent's Usi	ual Occu	pation			16b. Kind	of Business		
7		pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	F)	(Giv	DO NOT	ork done use retire	during mos d)	t of work	ing				,
7	filed within Hygiene. thar than "	PO	12	2	<i>'</i>	Ke	quster.	ed 1	durst			C 4	nd P	Telep	hone
B		Be (17. Father's Name (First, Middle, Last)						18. Mothe	er's Nam	e (First, Middle,	Malden St	umeme)		
<u>a</u>	should be ind Mental marked or umatic eve	To	Marshall B.	Donnes						MA	ry A.	Spar	'Ks		
a	2 sho end l is me		19e. Informant's Name/Reletionship (Ty	pe, Print)		19b. Ma	iling Addres	s (Stree			al Route Numb	er, City or T	Town, State,	Zip Code)
	1 end 3 Health arm 27 l		Barbara N. H.	ATOZ		2	Deer	- Av	٤.	Shir	-ley, M	A55.	014	64	
altimore,	of He		20a. Method of Disposition		20b. Plac	a of Dispetery, cr	oosition (Ne	me of other pia	ce)		Date 23	20c. Loca	ation - City or	Town, St	ate
Ĕ	Pages nent of I ant: If Its iry or of		1 Burlel 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		ento	p.	empl		1	1998	1)enton	MAY	MAND
Dall	permit. Pages 1 en Depertment of Heal Important: If Itam 2 any Injury or other once.		21. Signeture of Funeral Service License)e			22. Name e	E		Eunt	ral cha		m MD.	2.	4.
			23a. Pert1. Enter the disease, or complishock, or heart failure. List only on	cations that caused	the death.	Do not e	oter the mo						י עוון	-	> 9 3 oximate
V	Physician /Medicai Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	Colon	Que to (or a):							
oc,	rifficete be executed ng physician end se the buriel-transit	ai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	С	Due to (or a	s a cons	equence of	:				-			
DOX 00/00,	000	in/Medical	that initiated events resulting in death) Last		ue to (or as	a conse	equence of)	•							
	0 0 0	Physician/	Part II. Other aignificant conditions con	tributing to death but	not resultin	ng in the	underlying	cause di	ven in Part I		23b. Did 1	tobacco us	te contribut	to the c	ause of death?
5	t the	hys				·9 ··· ···	andonyg	oudoo g.	on my ditt	•	1 🗆				4 Unknow
	and se de	by F												,	
DIVISION OF VICE DECORDS,	The law requires thet the ate hes been signed by the page 2 should be deteched.	Completed I									24e. Was perfo	an autopsy med?		aveileble	on of cause
č	The lav	E									10	res 201	No	1 ☐ Yes	2 No
9	definer: The	BeC	25. Was case referred to medical						26. Plece	of Deat	h (Check only o	ne)			
>	Physician: r this certific and director,	To	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatien	t 2 ER	VOutpation	ent 3 D	OA Ot			me 5 Resid		☐Other (Spe	cify)	
2	g Ph ser th		27. Manner of Death	28a. Date of Injury (Month, Dey	Vear) 28	Bb. Time Injury	of	28c. Inju Wo			28d. Describe I				
5	Attending or deeth.	atic	1 ✓ Natural 5 ☐ Pending investigation	(Month, Doy	7 04.7	піјагу	М		Yes 2□	No					
	al or Attendests efter deet	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injur building, etc.		, farm, s	treet, facto	ry, offica			28f. Location (S City or Tox		Vumber or Ri	ural Route	Number,
	To the Hospital or Attending Physician: The I within 24 hours effer deeth. To the Fureral Director: Atter this certificate h completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) 12 Medical Examin	Iclan: To the best of er: On the basis of e end manner state	examination	dge, dea	th occurred	at the ti	me, date en opinion, dea	d place, th occur	end due to the red at the time,	cause(s) ar date and pi	nd menner as lace, and due	s steted. to the ca	ause(s)
	Mithir To th	Me	29b. Signature end fille of certifier	0	1	1	29	c. Licens	se number			29d. Date s	signed (Mont	h, Day, Y	ear)
	, , , , ,		V7/1 17	2 002	2			5	441	7.9	3	41	20198	/	
	67		30. Name and address of person who con	moleted cause of de	ath (Item 25	Re) (Turv	Print\	-	1 11			1/	20/10		
1			DR. PENELOPE EI		300 DU			TEV	מת	TT 3.60	ATTIM:	m 014	002		
	Sta	te	31. Dete filed (Month, Day, Yeer)	32. Register			VAI	ALCY O	KD.	TIMO	ONIUM, N	W_21(193		
	Danista		APP 2 3 10		May way	don'-	-Mantaria	Photo:							



State of Maryland / Department of Health and Mental Hygiene 8 2 7

Certificate of Death Item#17 per FH G759 4/4/98 EW 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 22, 1998 **Physician** Hanh Thi Nguyen 3:45 am /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 Bonbon Court Baltimore Reisterstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Statement, Day, Year) | 1948 | Vietnam 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 20 F Months 49 Yrs. 215-11-1966 Director Usual Residence of Decedent the Marylend r 28a-f ahow notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Reisterstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Medical Examiner must be r U.S.A. 21136 9 Bonbon Court permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23. eny Injury or other traumatic event, the Menice Exam or main Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 D to If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Packer Cup Factory 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOI Kieu Quang Nguyen Su Thi Nguyen 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Bombon Ct., Reisterstown, Md. 21136 Thao Phuong Tran Baltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cem. Apr. 24, 1998 Pikesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part (Enter the disease, or complications that caused the shock, or heart feilure. List only one ceuse on each line Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, **Physician** Carcinomi ox /Medical Immediate Cause (Finel disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): for use as 23b. Did tobacco use contribute to the cause of death? ed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 Ne 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? been si 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Physicien: Be 25. Was cese referred to medicel director 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1□ Yes 2☐ No 70 this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury el Work? 28a. Date of Injury (Month, Day Year) 28b Time of Certification: After t 5 Pending Investigation or Attending 1 PNatural 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident within 24 hours after death To the Funerel Director: / completely filled in by the f 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 29a. Certifler 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. the 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Qay, Year) 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

Robert C. Mori IIY Burners Con L. Diss Reinfung Mid Robert 31. Date filed (Month, Day, Year) APR 23 1998 2115 32. Registrar's Signature State who vavidoon handale

DHMH 16 Rev 6/95

Registrar

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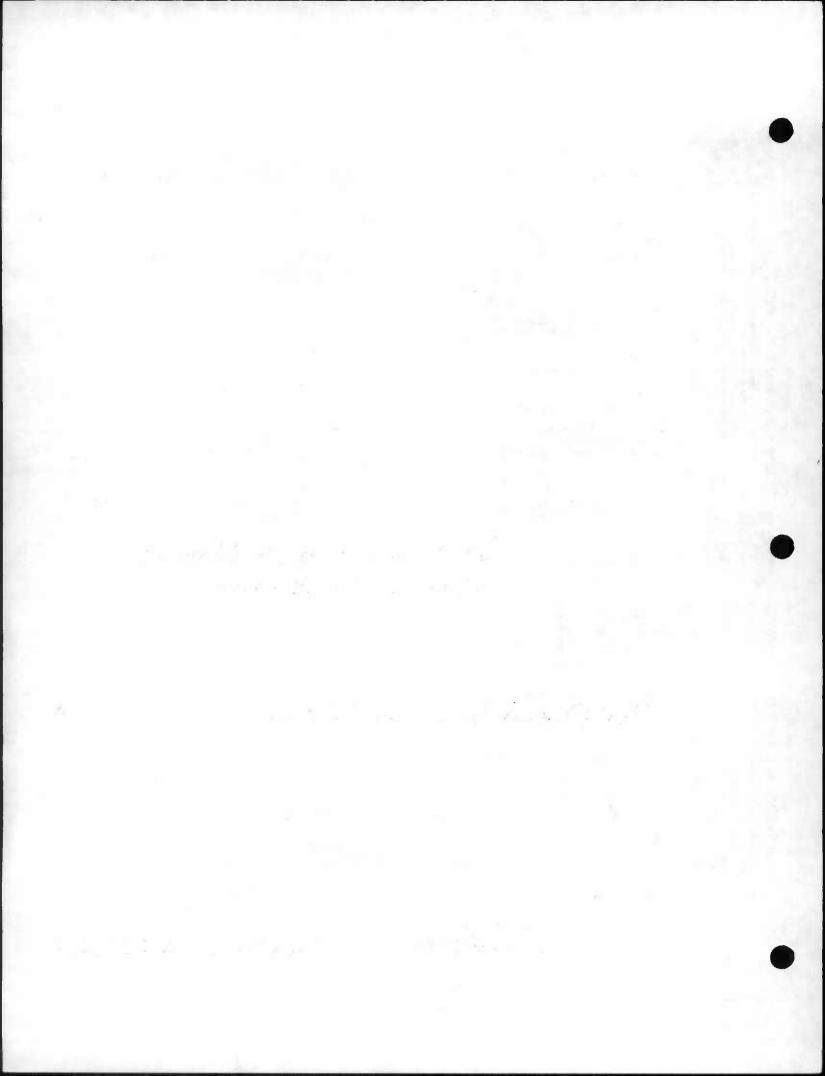
State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Clara V. Owens Apri :30pm 17,1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Parkway Parkville Perring Baltimore Eldercare Genesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days 1□ M 200 F 220-24-4435 85 Director July 12,1912 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Medical Examinet must be notified at 1 Yes 2 No Parkville Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2.12.34 U.S Dundas permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "nature!", or Items 23s Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 250No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Retai Cashier 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mary Adam G. Daylor Boyd Snyder 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) , mD 21234 Parkville Steiner Mary Dundas CT. 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 21, 1 Suriel 2 Cremetion 3 Removal from State Baltimore, MD 1998 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 22. Name and Address of Facility
Evans chapel of memores 21. Signature of Euneral Service Licenses 8800 Harford Rd. Parkville, MD 21234 23a. Pent1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Hours direct Immediate Cause (Finat disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner the ettending physician and ned for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 88 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown signed by þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No r death. within 24 hours efter deat To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 90 4 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) Ziad MirzA M 3007 E. Northern PKWq Baltimore, MD 31. Date filed (Month, Dey, Year) APR 23 1998 32. Regis al s Signature

DHMH 16 Rev 6/95

State Registrar

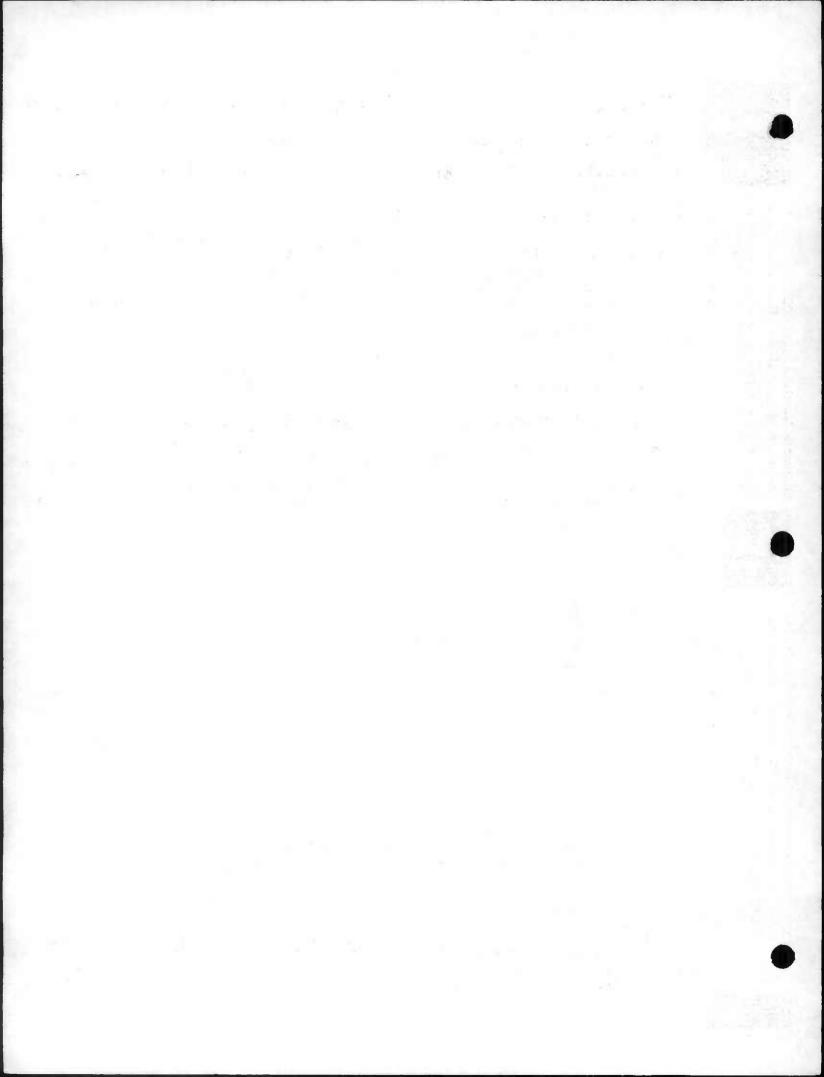
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



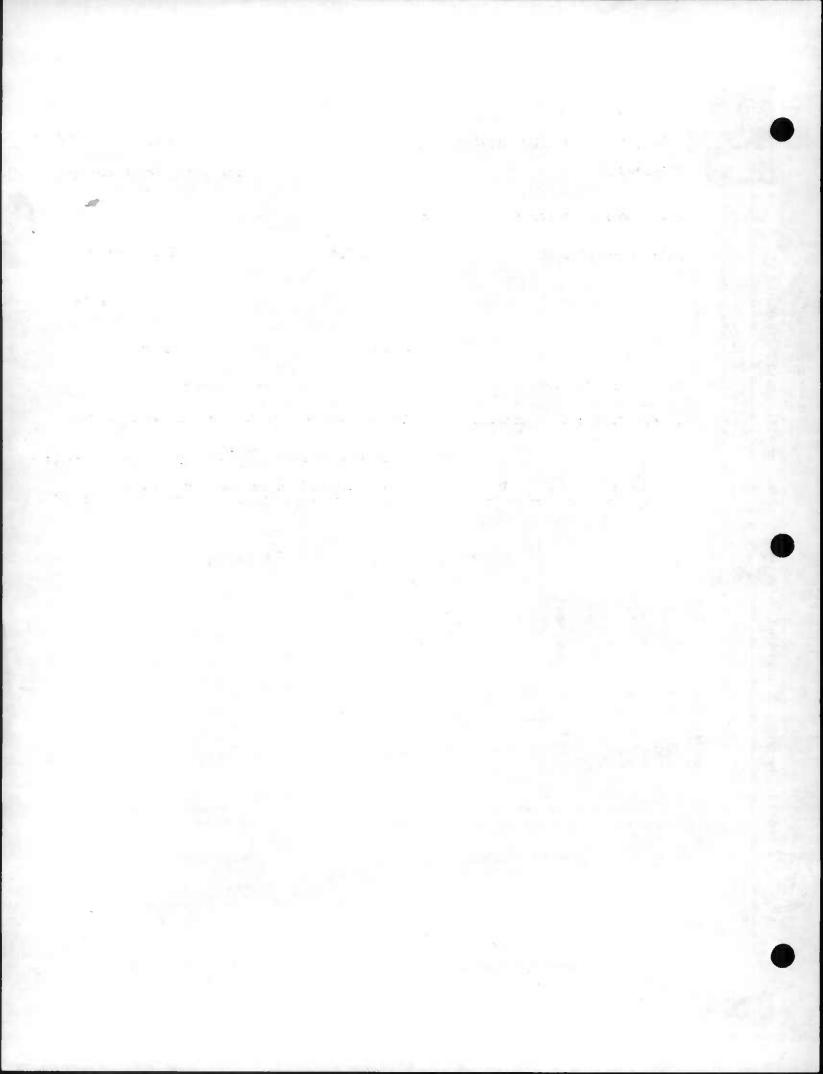
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	dae	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forcas?	ar in U,S.	13. Wa	s Decedant of H	lispanic Origin? (Specify Yas or No to Ricen, atc.)	14. Rac	ce - Americen ck, Whita, atc.	
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland Haalth and Mental Hygiene. Haalth and Mental Hygiene. The marked other than "naturel", or Hema 23a or 28a-f show other traumatic event, the Medical Examinet must be notified at	þ	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 Tas 2 No If Yas, Giva Yaar or Datas:)			Specify:	to Theory, actory	Specif	1	
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State of Maryland / Department of Health and Mental Hygiene 8 12874

		Ce	rtificate of	Death		Reg. No.	I L. U I
Di cololos	Decedent's Name (First, Middle, Last)	4	DT	-010	2. Dete of D Month	eath Dey	3. Time of De.
Physician /Medical	MARGARET W.		PLE	KCF	April		998 07:10
Examiner	4e Fecility Neme (If not institution, give street and number)			4b. City, Town, or			
Funeral	North Arundel Hospit 5. Social Security Number 6. Sex 7. Age (In yrs. 578-54-9016 1□ M 2⋈ F 55		1	If Under 24 Hrs Hours Min	8. Dete of B (Month, D	irth lay, Year)	9. Birthplace (State or Fo
Director	Usuai Residence of Decedent				sept.	10,1942	Washington,
ž ==		ty, Town or Lo	ocation				10d. Inside City L
to to	Maryland Anne Arundel Jes	ssup					1 ☐ Yes 25
or 28a-f a be notified Director	10e. Street end Number		10f. Zip Code			10g. Citizen of	
23.	1833 Montevideo Rd.		20794			United	States
al', or items 23a or 28a-f ahow Examinar must be notified at by Funeral Director	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates:		Was Decedent of Hit Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Ilspenic Origin? (San, Mexican, Puer Specify:	Specify Yes or N no Rican, etc.)		ce - American Indian, ick, White, etc. Ty: White
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d Mental hygiena. marked other than "natural", imetic event, the Medical Exe To Be Completed by	Elementary/Secondary (0-12) Coilege (1-4or 5+)	Homen	DO NOT use retired	d)	nnig	Own Ho	me
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arked out atic ever To Be	Francis M. Wallace				D. Dix		
Tarke Tarke To		105 14-11	ing Address (Ctor				State Zin Code
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upperment or featin and Mental intygiens. reportant: If feat 27 is marked other than "nature any injury or other traumatic event, the Medical pace. To Be Completed	20a. Method of Disposition 1 ဩ Byriai 2 □ Cremation 3 □ Removel from Stete	cametery, cre	osition (Name of omatory or other place)		Date April		- City or Town, State urnie, Maryla
Departme Important any Injury ance	21. Signature of Pulletel Service Licensee	K	2. Name and Addre	ess of Fecility	uneral H	Home, P.	
ng physician and e as the burial-transit Medical Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause, (Disease or injury c. Fut	or as e consecutive or esta consecutive or est	nia				11 day
he alland hed for use ysician/	Part II. Other significant conditions contributing to death but not res	sulting in the u	underlying cause giv	ven in Part i.	23b. Die	d tobacco use co	ontributa to the cause of d
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should be leted b	Thrombocytopenia, Congest Asthma, Paraplesia,	Neur	opathy		24a. Wa	s an autopsy formed?	24b. Were autopsy tindi eveilable prior to completion of caus of death?
page 2					10	Yes 2 200	1 ☐ Yes 2 ☐ No
certificate has inscior, page 2 b Be Comp	25. Was case reterred to medical examiner?				eth (Check only	one)	
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	27. Manner ot Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date ot injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ∣Yes 2 ∐ No	28d. Describe	how injury occu	rred
outs also death. eral Director: Aher tilled in by the funeral direction: al Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At h-building, etc. (Specification)	ome, tarm, st	treet, factory, office		28f. Location City or T	(Street and Numown, State)	ber or Rural Route Number
dlos	29a. Certifier (Check only one) 1 ☐ Certifying Phyeician: To the best of my kno (check only one) 2 ☐ Medical Examiner: On the basis of examine and manner stated.						
To the compli	29b. Signature and title of cartitier		29c. Licens				ed (Month, Day, Year) 18, 1948
	30. Name and address of person and caudleted cause of deeth (item	n 23a) (Type,	, Print)	Din	the Hi	uncles	18,1948 Hospita
State	31. Date Man Wheth Day 1900 32 Flepist T. Signe	eture Bands	100	, , - 0 / .	777		



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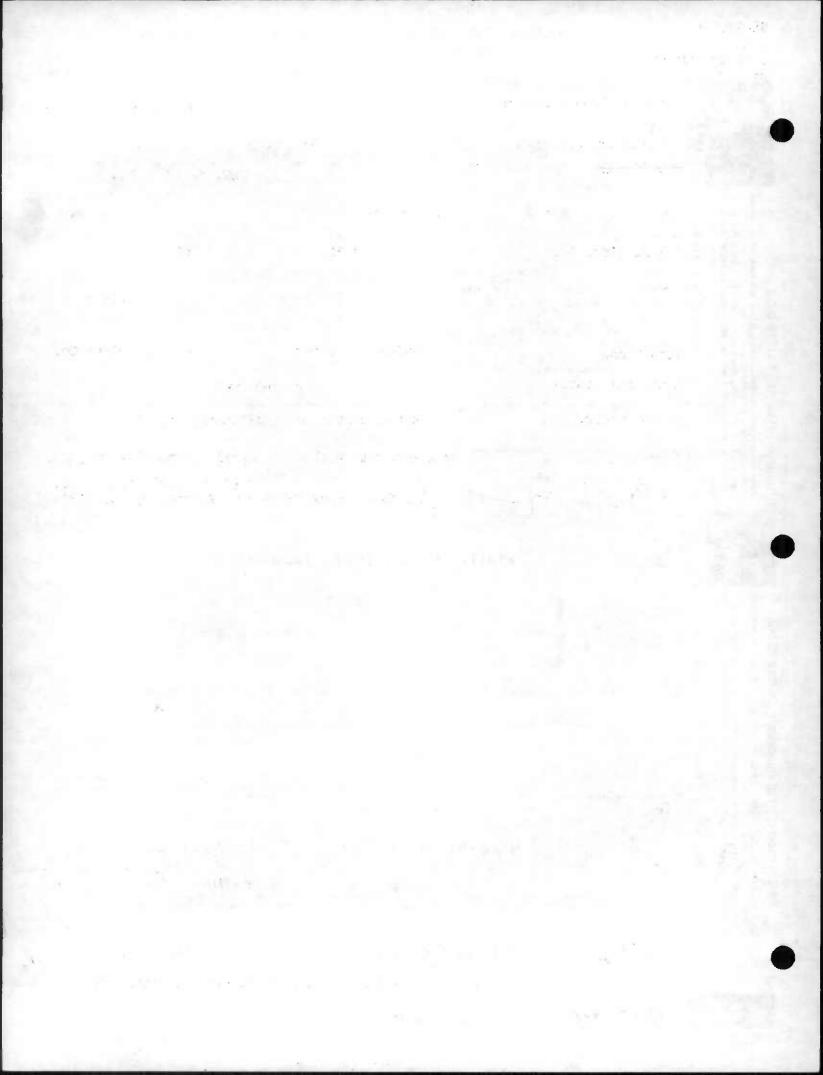
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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

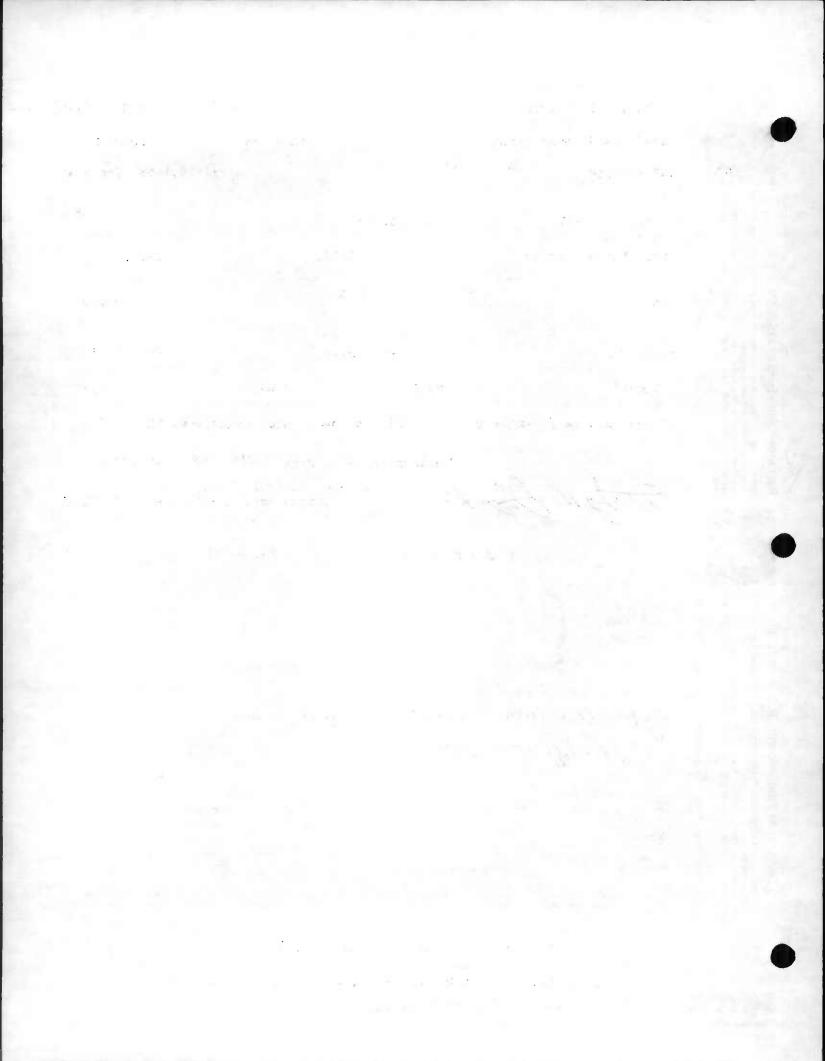
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i N	/Medica Examine	_	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of D						ocation of Death				
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	Funeral Director		5. Social Security Number 218-68-1580 7. Age (In yrs. last birthday) 1 M 2 F 85 Yrs. 1 Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) FEB. 3, 1913 9. Birthplace (State of Country) MARYLANI										
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w .	ent of H nt: If Ite ry or ot		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of come of BET	of Disposition (ery, cremetory H EL ME	(Name of or other plea EMORIA	L PARK	Date 4-22-1	20c. Location - Ci 998 RANDA		TOWN, MD	
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5	within to program or Attentioning within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, farm, street, factory, office 28f. Lo						ocation (Street and Number or Rural Route Number, ity or Town, State)				
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	17	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							28	2/04			
	12	- 23	0. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRICIES MOORE I 6340 WOODCREST DR Ellicott City MB										
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 2. Data of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Death Month Day Yaai **Physician** 12:45 a.m. Ruby Pemberton April 14, 1998 /Medical 4c. County of Deeth 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2647 Sandymount Road Finksburg Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 72 Yrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Days Months Hours 407-30-2368 April 10,1998 Kentucky Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or frems 23e or 28s-f show any Injury or other traumatic awant, the Medical Evaprime, must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1X Yes 2 □ No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2803 Sunset Drive 21223 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Black, Whita, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th. Grade Own Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samue1 Pack Nannie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Alkire / Daughter Patapsco Road Linthicum, MD 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 ABurlal 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 04/16/1998 Elkridge, MD 22. Name and Address of Fecility
Hubbard Funeral 21. Signature of Fungral, Service Licensee Home, Inc. 4107 Wilkens Ave. Baltimore 21229 23a. Part1. Enter this sease, or consolications that ceusad the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onsat and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) Carcinoma /Medicai 1 mo Examiner Examiner The law requires that the death certificate be executed physician end s the buriai-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequance of): Box 68760 Physician/Medical Dua to (or as e consequence of): 80 for use es P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown congestive heart failur þ Division of Vital Records, 24b. Were autopsy findings evallable prior to completion of causa of deeth? Completed 24a. Wes an autopsy Hypolkyroidism 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 20℃No Certification: To this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 Yes 2 No within 24 hours efter death.

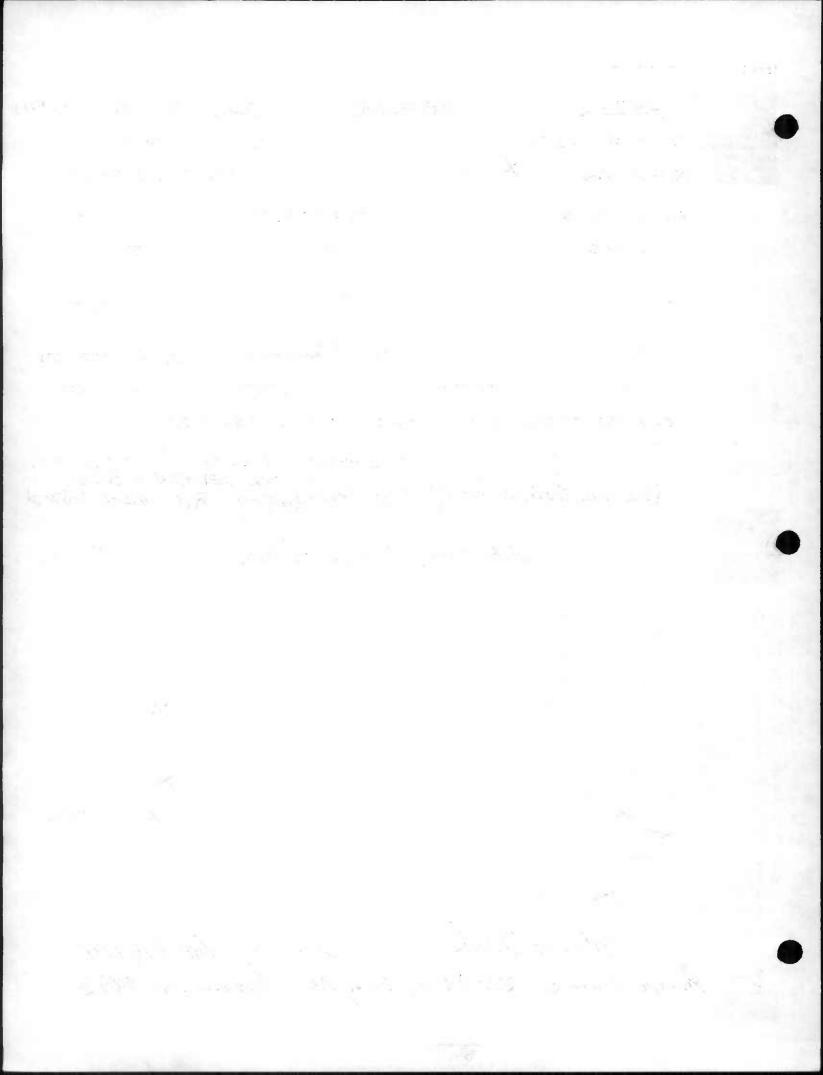
To the Funeral Director: Al
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 29a. Certifier edicai 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and menner stated. (Check only one) 29d. Date signad (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 221649 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 21229 Baltimore MD 3455 Wilkens Ave Dr. Baskaran 31. Date filed (Month, Day, Year) APR 2 3 10 32. Pegietrer's Signature State Registrar

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Physician Middical Examiner 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Beyond Proposition of the property of the	Dall permit. Departm Imports any Inju		21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility SQL LEVINSON & BROS.									
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30. Name and address of person who completed cause of deeth (Ham 23e) (Type, Print) Kenelope Edwards 2300 Wanes Valley Rd. Timonian Md 21093	To the Within To the		29b. Signeture end title of certifier 29c. License number									
30 Renewe Edwards 2300 Waner Valley Rd. Timonian Md 21093			20 Name and address of access to	completed source of death or	am (12-) (T	Deint\	14416	Ma	R1/19,	1448		
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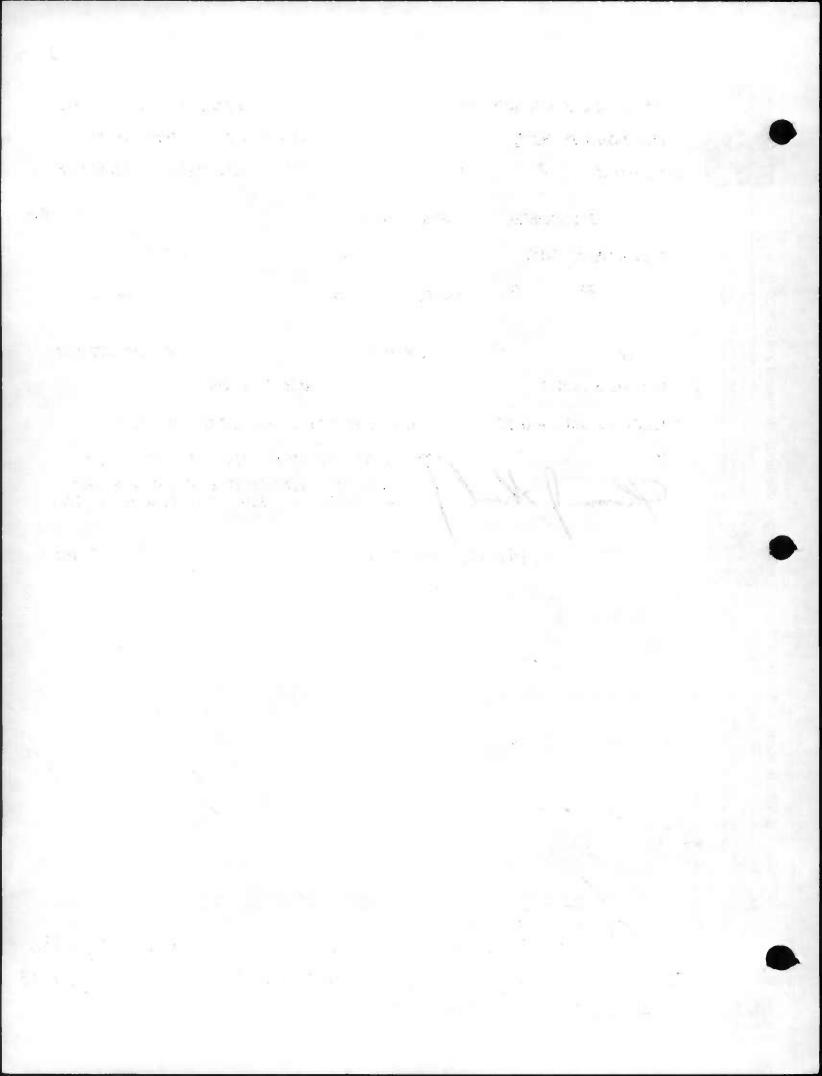
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Funeral Director		5. Social Security Number 6.		(In yrs. last birt	1	der 1 Year if Under	24 Hrs. 8. Date of (Month,		9. Birthplace (Country)	(State or Fore
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020	be fled within 72 hours after death with the Maryland the Hydiona. Hydiona. do other than "natural", or items 23s or 28s-f show svent, the Madical Examiner must be notified at Be Completed by Funeral Director.	11, Marital Status 1 Never Married 22 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1XXVes 2[If Yes, Give Year or Date:	s? 1944-46	5	Was Decedent of Hif Yes, specify Cub			Rican, etc.)	Bla	ck, White	, etc.
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5		Johns Hopkin	S AT	of death (Item 23	Ba) (Type,	Print) 6 1075	S FA	ccs	RD :	APRIL Suité	200	21093
	State Registrar	31. Date APR 2 3 1998	gate	Bush Haven	fandel	٤						



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7				Otate of Ivia	ii yiai i		ificate of	Death	nernar i iy	Reg. No.		2001
Phy	/sicia	n	Decedant's Name (First, Middla, Last Henry Pete Stewar						2. Data of Da	Day	Yaar	3. Time of Daath
	ledica amine		4a. Facility Nama (If not institution, giva		5 185			4b. City, Town, or Lo	ocation of Daat	h 4c. County	998 of Death	10 -pm
			Gilcrest Center					Towson			Balt	imore
Fune Direc				311 - 5 -	(In yrs. 1 77		if Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da Jan. 8	y, Yaar)	9. Birthp Coun S.C.	placa (State or Foreign stry)
e Maryland	to peggi	ctor	Usual Rasidance of Dacedant 10a. Stata 10b. County Md. n/a			, Town or Loca Baltimon					1	0d. Insida City Limits
th with the	ust be no	Funeral Director	10e. Street and Number 851 Fivesham Avenue	9			10f. Zip Code 21212			10g. Citizan of V USA	Vhat Cour	ntry?
1020 () ours after death with the Marylac nal, or herre 23a or 28a-f ahow	Examiner m	P	11. Marital Status 1 □ Naver Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Dacedant E Armad Forces? 1 ☐ Yes 250N If Yes, Give Yaar or Datas:	7.17	lf Y	as Decedant of H Yas, specify Cub	dispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yas or No Ricen, atc.)	Blac	e - Amaric ck, Whita,	
21215-0020 swithin 72 hours at plane, t than "natural", or	ne Medical	Completed	15. Dacedant's Edu (Specify only highast grad Elemantary/Secondary (0-12) 8th Grade	icetion la <i>complatad)</i> Collega (1-4or 5-	+)	16e. Deceder (Giva kir lifa. DC Steelwo		pation during most of work d)	ing	16b. Kind of Bu		teel Corp.
and 2		Be	17. Fathar's Name (First, Middla, Last) Sheldon Stewart			Sceeiw	DIKEL	18. Mother's Name Ida McDa				teer wip.
Maryl nd 2 should alth and Me	r traumatic	To	19a. Informant's Name/Ralationship (7) Willa D. Cox	rpe, Print) daugh	iter			and Number or Run Avenue Bal				Coda)
More, repert a	ry or othe		20e. Method of Disposition 1	Ramquer from State	Ce		ion (Nama of tory or other pla tar Ceme		Data Oril 21	20c. Location -		
	any inpu		21. Signature of Funeral Service Com-	De la	5			nss of Facility Nut				
Physici	lan		23a. Párt1. Entar tha disease, or compl shock, or heart feilura. List only o	ications that caused na cause on sech in	the daam	Do not enter	the mode of dyli	ng, such as cardiac	or respiratory a	rrest,	T	Approximate Intervel Batwaan Onset end Deeth
/Media Examin	ner		Inmediata Causa (Final disaasa or condition rasulting in death)	a end	S+	Age (CArdio	myopi	athy			years
and and	-transit	Examiner	Sequentially list conditions, if any, leading to immediate	b. —	Dua to (or	as a consequa	nce of):					
68760, ifficete be executed a physicien and ground transfer.	the por	edicai E	Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Ceusa (Disaasa or injury that initieted avents resulting in death) Last	O	oua to (or	as a consequa	nce of):		9 5			
- D	0 .	_		d	150							
O. Box		Physician/N	Part II. Other significant conditions cor	ntributing to death bu	not rasu	ilting in the unde	arlying ceusa giv	van in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
T 6 5	e detached	by Phy	renal S	alure)				10	Yes 2 No	3 Prof	bably 40 Unknown
aw requ	a spoula s	Completed							24a. Was	an autopsy ormad?	av	ere eutopsy findings ailabla prior to mplation of causa deeth?
- F 50	eßed	Cod							10	Yes 2 No	10	Yas 2□ No
of Vital I Physicien: The	rector	o Re	25. Was cesa raferrad to medicel axaminer?	lospital:			Oth Oth	26. Placa of Deet		10		//
Phy Phy	m '	-	1 Yes 2 No 27. Mannar of Death 1.⊠ Natural 5 Panding 2 Accidant investigation	28e. Deta of Injun (Month, Day	,	ER/Outpatient 28b. Time of Injury	28c. Inju	4 LI Nursing Ho		dance 6 NOth how Injury occur	ar <i>(Specif</i> red	n) Hospir
or Att	eur by the	Certification:	3 Suicida 6 Could not be datarmined	28e. Place of Injubuilding, atc.	ry - At ho (Spacify	me, farm, stree	t, factory, office		28f. Location (City or To	Street end Numb wn, Steta)	er or Rure	ol Routa Numbar,
the Hospital		edical	29a. Cartifier (Check only one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Certifying Physical Examination (Check one) 12t Cer	alcian: To the best of ner: On the besis of and mannar stat	examinat	vladga, daath o ion and/or Invas	ccurred at the til stigation, in my c	me, dete end plece, opinion, death occurr	and dua to tha red at the time,	cause(s) and ma data and place,	anner as si and dua to	tated. o tha ceuse(s)
No Est	E COM		29b. Signature and tha of Certifiar	00)		29c. Licans			29d. Data signa	d (Month,	Day, Year)
Marie	7	-	30. Nama and address of persen who co	my local	ey	230) (Tuno B	(01)	Charles		Harl	-17	,1798
+13			W.A. Riley	GBM	2	6701	N- 1	Charles	St. f	Zelte	Md	1 5120X
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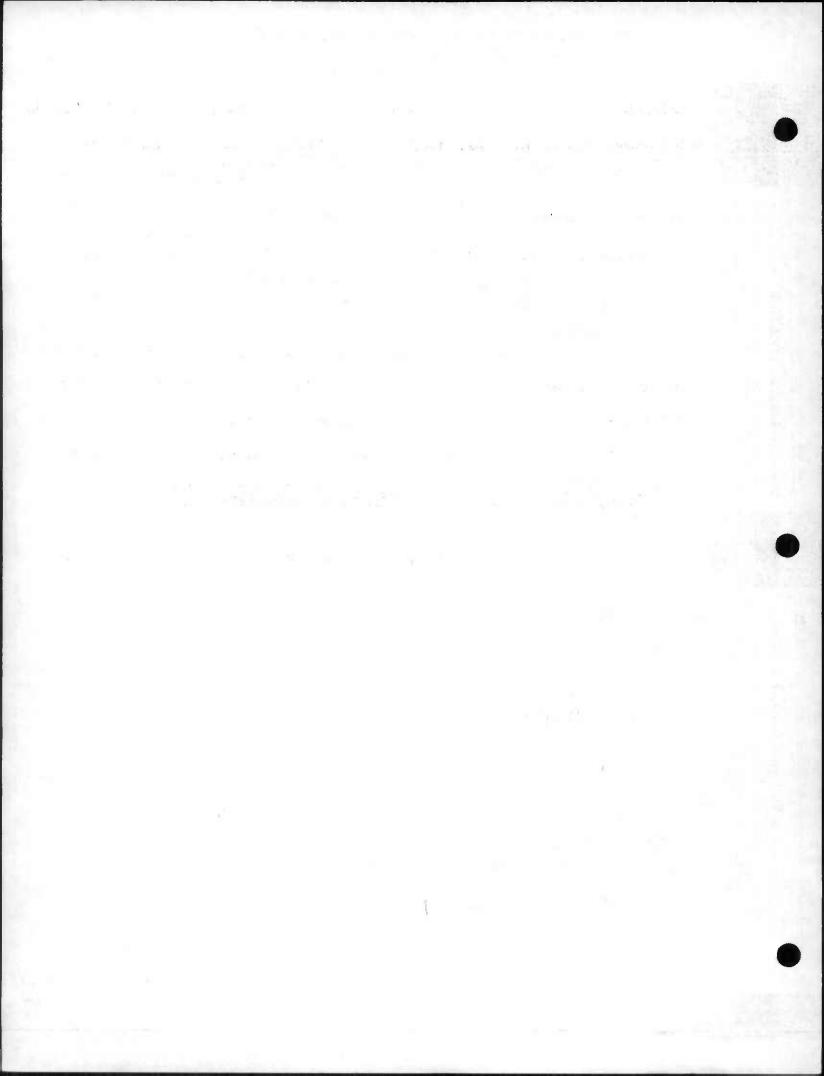
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State of Maryland / Department of Health and Mental Hygiene 98 2882

						Cert	ificat	e of	Deat	h		Reg. No.			
		7	1. Decedent's Name (First, Middle, La	ast)	-60						2. Date of De	ath		3. Time of Deeth	_
	Physici		WALTER (3	<	SHO	4PE				Month APRIL	2Z	1998	955 A	n
	/Medic Examir		4e. Fecility Neme (If not institution, gir	ve street and number)					4b. City,	Town, or Lo	ocation of Death		nty of Death	,,,,,,	-
	Exami	iei	5 PLEASANT RIDGE	~ ^	T. PH7	7		1	Julino	as M	1115	R	ALTIN	1000	
Н	Funeral				(In yrs. last bin	thday)	If Under	1 Yeer	If Und	er 24 Hrs.	8. Date of Bird (Month, Da	th		elece (State or Foreig	חנ
	Director		512 01 6989 Usual Residence of Decedent	1 X M 2□ F		Yrs.	Months	Days	Hour	s Min.	Jan. 2			ansas	
	show		10e. Stete 10b. County		10c. City, Town	n or Loca							1	0d. Inside City Limits	s
	the Mery 28a-f sh	Director	Maryland Balti	more					gs M	ills		40	-1112 - 1	1 ☐ Yes 2 ☐XNo	D
	be filed within 72 hours after death with the Meryland tall Hygiene. Id other than "natural", or Hems 23s or 28s-f show event, the Medical Examiner must be nomined at	rai Dir	5 Pleasant Ridge		t. PH7		10f. Zlp			1117		Unit	of What Cour ed Sta	ites	
	er de	Funeral	11. Maritel Status	12. Was Decedent E Armed Forces?		13. W	as Deced Yes, spec	ient of i	Hispanic (pan, Mexic	Orlgin? (Sp can, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,		
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5-	72 h netu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	(Give ki	nt's Usua	rk done	during m	ost of work	ina	16b. Kind o	f Business/In	dustry	
121	ithin se	현	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)	life. Do	O NOT us	se retire	ed)			- 1			
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Baltimore,	8 - 2 0		20a. Method of Disposition 1 ☐ Burial 2 ②Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Placa of cameter Green	y, creme	etory or o	ther ple		4/2	Date 3/98		on - City or To		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Servica I			CA	FA S	Step		D. Lo	hrmann s Dr.,		oro N	D 21286	
	_		23a. Part1. Enter the disease, or com	polications that caused	the deeth. Do r								ore, r	Approximate	
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	/Medical		Immediate Cause (Final	10	12hei	0.0	_ (1.0	4.01	2				110	
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	ored d ansit	Examiner		b	Due to (or es e o	200000011	ones of):								
ć	exec n an	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury		Due to (or es e c	onsequi	erica or).						1		
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	ertificate be executed ling physician and e es the buriel-transit	Medical	resulting in death) Last		740 to (01 03 a c	onseque	silica Oij.						1		
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Records,	requir een si hould	Completed									24a. Wes perio	an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?	
R	0 4 9	E C									10	Yes 2 PN		Yes 2□No	
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>		o Be	exeminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Ou	teationt	3□ DC	Ot	hor:		me 5 Resi		Other (Specif	641	
of		-	27. Manger of Death	28e. Dete of Injury	y 28b. T	Time of		8c. Inju		redising ric	28d. Describe			y)	
O	ding h. Th. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	Year) In	njury	М		ork?]Yes 2	□No					
Division	or Attending after death. Director: After i in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b	On Plant of letter	ry - At home, fa	rm, stree	et, factory	, office	2		28f. Location (Street and No	ımber or Ruri	al Route Number,	
S	after Dire	erti	4 Homicide	building, etc.	. (Specify)	,	.,,	,			City or To	wn, Stete)			
٦	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Example 12	nysician: To the best of miner: On the basis of	examination and	, death o	occurred s	at the ti	ime, date opinion, d	and pleca, leath occur	end due to the red at the time,	ceuse(s) and dete and ple	manner as s	tated. o the cause(s)	
	To the I within 2 To the I complet	Med	one)	end manner stat	ted.		200	Linn	ea numbe	Mr.		29d Data si	and (Month	Doy Veer!	
	0 1 × 0	-	29b. Signature and title of certifier	100	k. 0.		290	-	se number			250. Date Si	aned (Month,	GQ.	
	\		Villen	tocc	roson	42						7	122	10	
	\mathcal{O}		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, P	nint)	, 1	1011	Den	ve 51	11 SH	C.d.	14. 4. 1. 1. 1. 1.	. /
			31. Dete filed (Month, Day, Year)	32. Registra	480	שעו	1564	V	119-11	001.1	ve 21	1100-01	COPY	2100	4
	Sta Registr		31. Dete filed (Month, Day, Year) APR 23	1998	who David	son-1	fandal	2							



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	Cortificato	of	Death	

epartment of Health and Me	ental Hygiene 9 8	2	8	8	3
Certificate of Death	Reg. No.				

2. Date of Deeth

Month

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last) ALEXANDER WILSON SCHWEIZER 4a Facility Name (If not institution, give street and number)

04 4b. City, Town, or Location of Deeth

3. Time of Death 9:16PM.

SINAI HOSPITAL

BALTIMORE

4c. County of Deeth N/A

Year

Day

17,1998

Funeral Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at

the Marylend

death

2 should be filed within 72 hours effer end Mental Hygiene.

pemit. Peges 1 and 2.
Department of Health er
Important: If item 27 fa
any injury or other trau

Physician

/Medical

Examiner

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Mospital 24 hours a Funeral C

Examiner

Physician/Medical

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Completed

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To

Certification:

Medical

Maryland 21215-0020

altimore,

Box 68760

P.O.

Division of Vital Records.

or Attending Physician:

Usuel Residence of Decedent 10a State MD.

Directo

Funeral

à

Completed

10b. County BALTIMORE

1MM 2□ F

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthday)

19

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours 04-12-1979

 Birthplace (State or Foreign Country) MARYLAND

5. Social Security Number

216-94-8136

BROOKLANDVILLE

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number

831 HILLSIDE ROAD

21022 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

Days

USA

10g. Citizen of What Country?

11 Marital Status 1 Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12YRS

STUDENT

EDUCATION 18. Mother's Name (First, Middle, Maiden Surname)

17. Fether's Name (First, Middle, Last)

THOMAS SCHWEIZER JR.

BARBARA WILSON

19a. Informant's Name/Relationship (Type, Print) THOMAS SCHWEIZER JR. (FATHER) 831 HILLSIDE RD. BROOKLANDVILLE, MD.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State THOMAS G.FOREST 04-21-98 OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

22. Name end Address of Facility

gunshot Wound

HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD.

23a. Part i. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Intra oral

Approximete Interval Between Onset end Deeth

1 Yes 2□ No

21022

Immediate Ceuse (Final disease or condition resulting in deeth)

Sequentially list conditions, if any, leading to Immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or es e consequence of)

Pert II. Other stanificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Wes an eutopsy performed?

1 Yes 2 □ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 4-17-98

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of Four ZOZY

28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how injury occurred Self - inflicted

6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) SUMS NOT WOULD VILLE Number of Rural Route Number, City or Town, State) 621 Hillside Kord

29a. Certifier (Check only one)

1 Netural

2 ☐ Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

O.C.M.E.

29c. License number

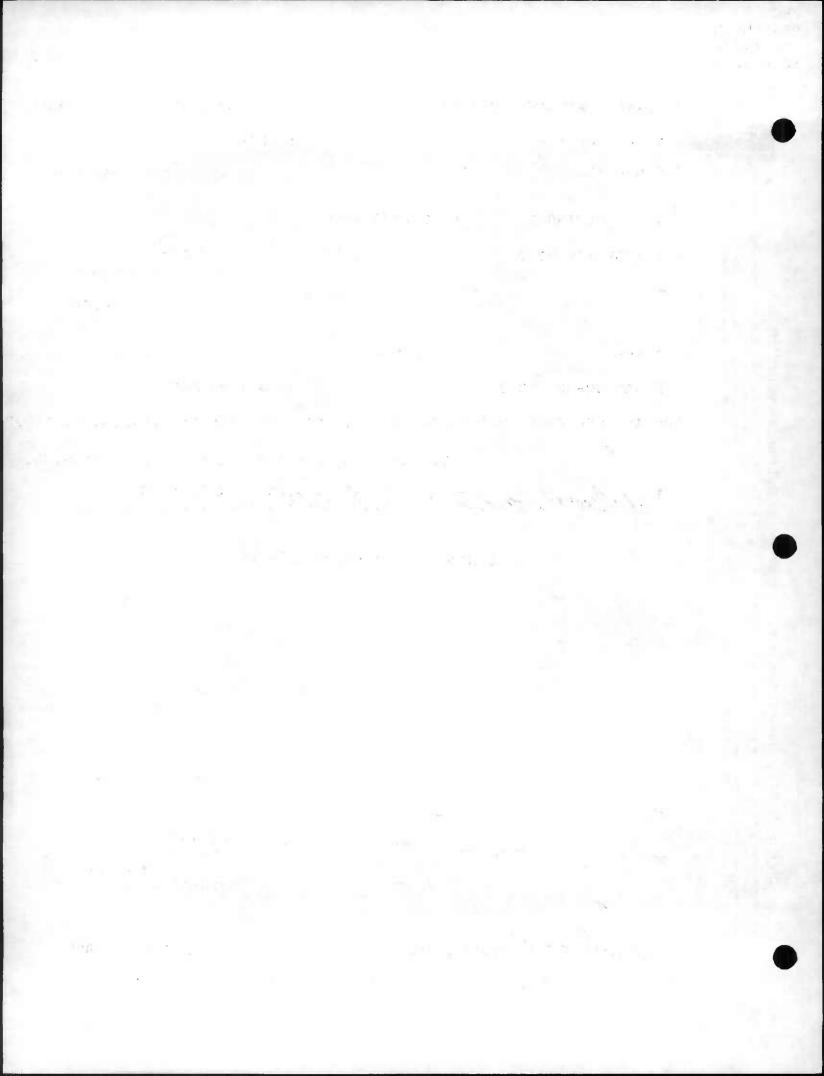
29d. Date signed (Month, Day, Yeer) APRIL 18,1998

5 Pending Investigation

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN S. PENN STREET, BALTIMORE, MD. 21201. RADENTZ, 111

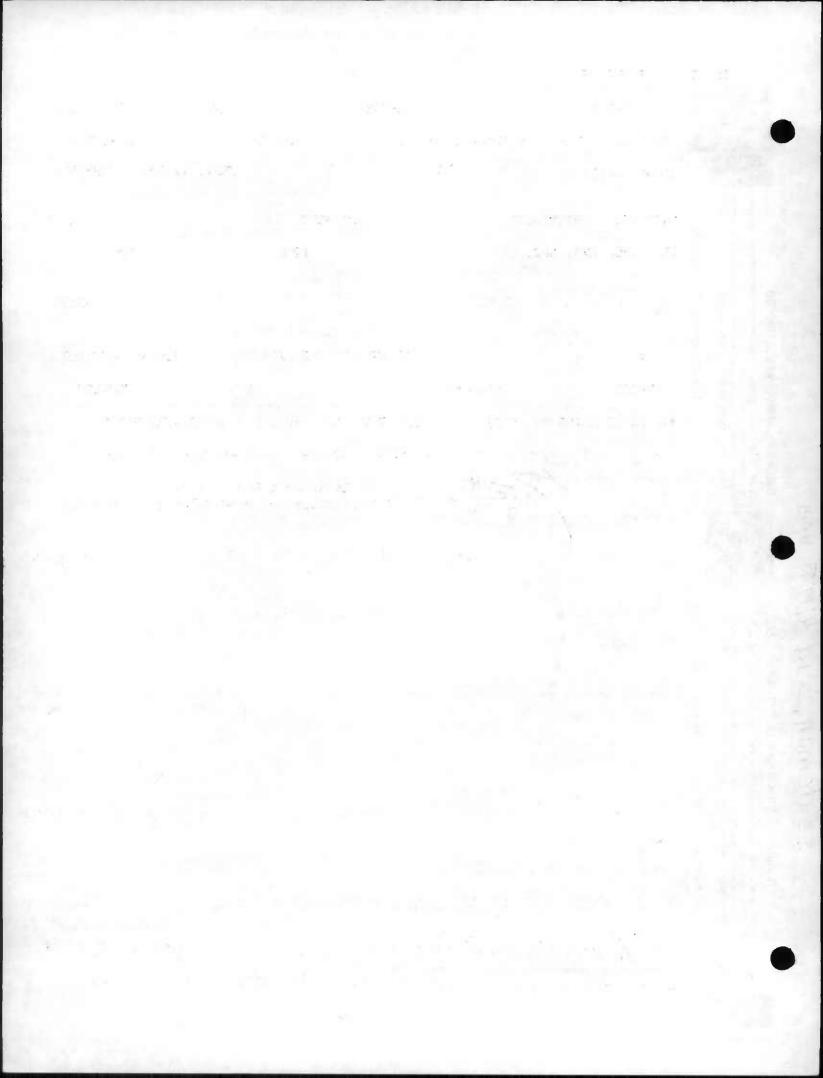
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by Funeral			ried 2 Marrie	ied	Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Dete	- No		Ves Deceden Yes, specify			ecify Yes or No Rican, etc.)		Rece - Amer Bleck, White pecify:	
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			Neme/Reletionsh RY SEIDE								8 BALTO			
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Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 3:40 AM APRIL 19,1998 STIEKMAN LILLIAN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner HURWITZ HOUSE - 135 SLADE AVE. BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 X F Yrs. 92 Director 218-50-6098 15, 1905 RUSSIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be nothed at MARYLAND BALTIMORE 1 X Yes 2 No N/A Director 10g. Citizan of Whet Country? 10e. Street and Number 10f. Zip Code 21215 2500 W. BELVEDERE AVE, APT. 420 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Heelth and Mentel Hygiena. Important: If them 27 ie marked other them only injury or other training. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Giva Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yea 2 No Specify: à 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN **HET.MAN** MARY **LEVINE** P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR.ROBERT STIEKMAN (SON) 6609 GREENSPRING AVE. BALTO., MD 21209 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State BETH ISAAC ADATH ISRAEL 4-21-1998 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Facility Sol Levinson & Bros., Inc. 23a. Part 1. Enter the disease, or complications that ceused the shock, or heart failure. List only one cause on each line.

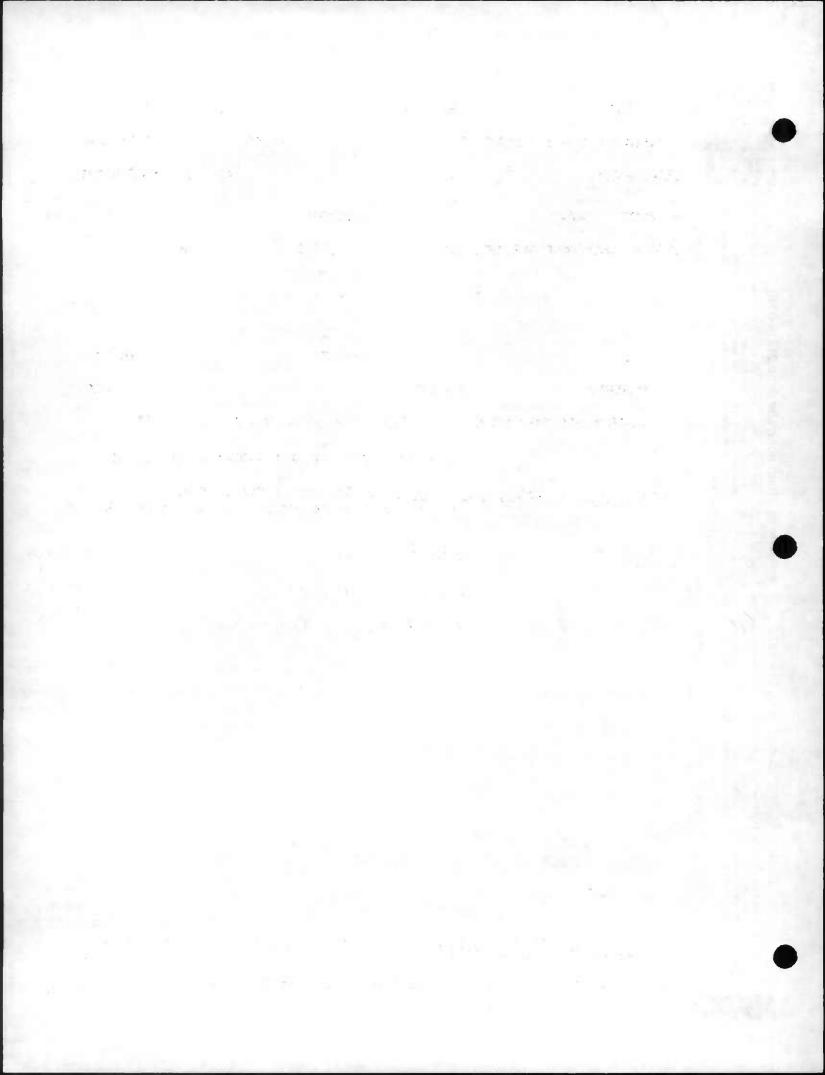
8900 Reisterstown Road Baltimore, MD Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth **Physician** Immediata Cause (Finel disease or condition resulting in deeth) /Medical Dehydration Examiner Due to (or as e consequence of): Examiner 10 Failure and -transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or aa a consequence of): Dans the death certificate becave physician ar 2 hiemes 's P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of): 980 23b. Did tobacco uen contribute to the cause of death? by the e Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires thet signed b Division of Vital Records. py 24b. Were autopsy findinga available prior to completion of ceuse of death? should 24a. Was an autopsy performed? Completed has certificeta ha 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was cese referred to medicet exeminer? director Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this funeral 28e. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred Certification: 28b Time of 28c. Injury at Work? 1 Natural 5 Pending investigation s after des. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be n 24 hours after des Ne Funeral Director Dietaly filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es stated. edical completaly 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner atated. (Check only one) To the To the To the 1 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) #300 Balto Md 21208 1638 Greentone

State Registrar W

32. Registrer'a Signature

Stulia Davidson-Randalle

31. Dete filed (Month, Dey, Year) APR 23



98-2206-510

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Hygiene 0

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SEXTON	Certificate of Death
DEVICE	

Physician /Medical Examiner

Funeral Director

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Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental hygiens. and the table share "natural", or itse and it is marked other than "natural", or itse uny or other traumetic event, the Medical Examine permit. Pages Department of Important: If its any injury or o

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician end the burial-transit the death certificate be executed 68 USB 10 signed by the a d be deteched f The law requires thet been si certificate has b Attending Physician: director, this funeral Affer death. the ector: To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 6

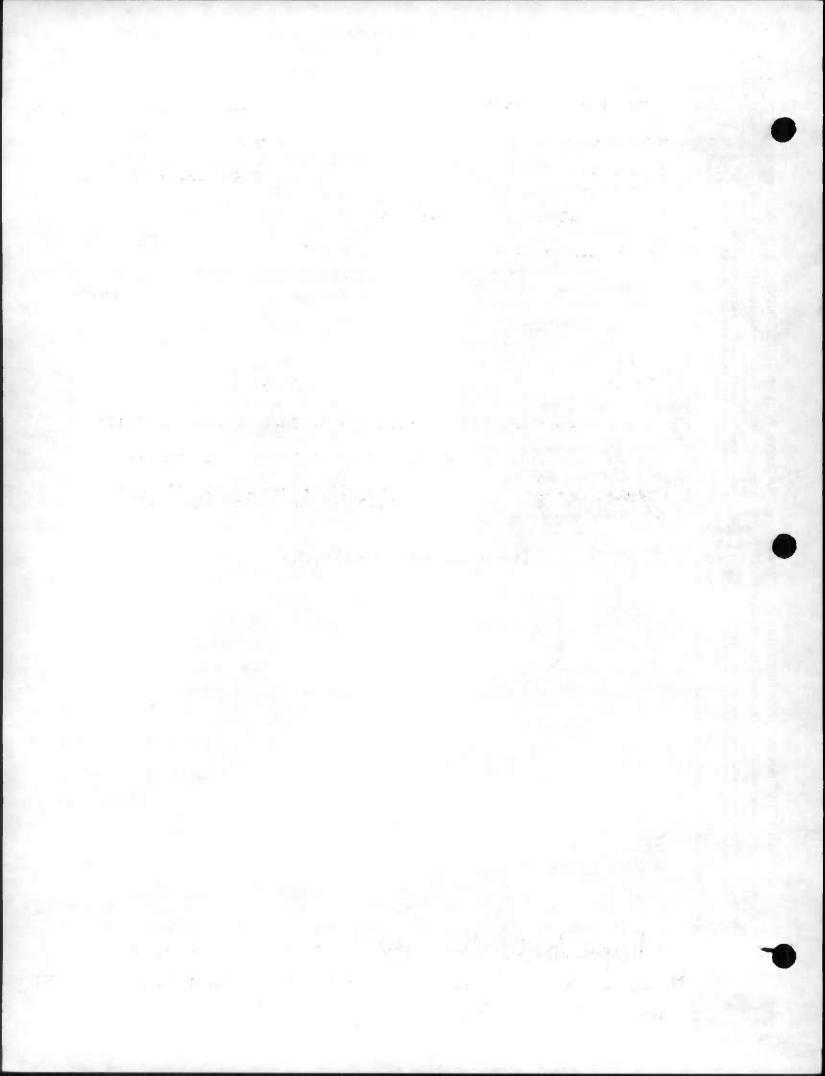
Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Shaun Michael Sexton APRIL 21,1998 11:45A.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) N/A JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Hours XXM 2DF 4 Yrs. 214-39-5757 May 26, 1993 Md Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Dundalk Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2529 Yorkway 21222 USA Apt. D 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown Nancy Sexton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 42 Fort Howard Md. 21052 Timothy Sexton uncle 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Sacred Heart Of Jesus 4-24 Dundalk 5 Other (Specify) 4 Donetion on of Lateral 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. 2n1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) , PNEUMOCOCCAL HEMMINS Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was en autopsy Completed 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Naturel 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner as stated. Medical (Check only one) Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature end title of certif 29c. License number 29d. Date signed (Month, Dev. Year) APRIL 22,1998 me O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) APR

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature whia faidon-Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Rudolp Month UPRIL 0242 16 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical System
17. Age (In vrs. lest birthday) It Under 1 Year Baltimore 5. Social Security Number If Undar 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys 102M 2□ F 218-74-9016 38 AVYLAND Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No more 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 805 5.A AVR 21212 12. Was Decedant Ever In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Naver Married 2 Marriad 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: 3 ☐ Widowad 4 ☐ Divorced BIACK 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAbor Clay S. TRASh Remove 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) MELVIN DeLoris 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) CROWE 11-Brother 805 CAbe JAME Mc BACTO. Md 20e. Method of Disposition 20b. Placa of Disposition (Nama of cametary, cramatory or other placa) 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Servica Licansaa md. 27213 Adway BALta le FuneRAL Home + Service 23a. Partt / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Immediate Causa (Final disaasa or condition resulting in death) unknown Saquantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiatad events rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evallabla prior to complation of causa of death? 24a. Was an autopsy parformed? 1 ☐ Yas 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

and

Physiclan

/Medical

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10a, Stata

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Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If flem 27 is marked other than "natural", or frems 23a or 28a-f show any injury or other traumatic event, the Medical Evants.

Baltimore, Maryland

Examiner Physician/Medical Completed by Be 2 Certification:

attanding physician for usa as the buria signed by the attaid

or Attanding Physician: The law requires that the death certificate be axecuted

certificate

After this

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after death

24 hours a Hospital

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in by

Medical

Box 68760,

Division of Vital Records, P.O.

25. Was case refarred to medical examinar? 1 Yas 2 No

27. Manger of Daath 1 Natural 5 Panding 2 Accident Investigation 6 Could not be datarminad 3 Suicida

4 Homicide

29a. Cartifian

28a. Date of Injury (Month, Day Yaar)

28a. Piaca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA 28b. Time of

28c. Injury at Work?

1 Yes 2 No

26. Place of Death (Check only one)

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Phyeician: To the best of my knowladga, death occurred at tha tima, data and placa, and due to the causa(s) and mannar as statad.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and dua to the causa(s) and mannar steted. 29b. Signeture end titla of certifie

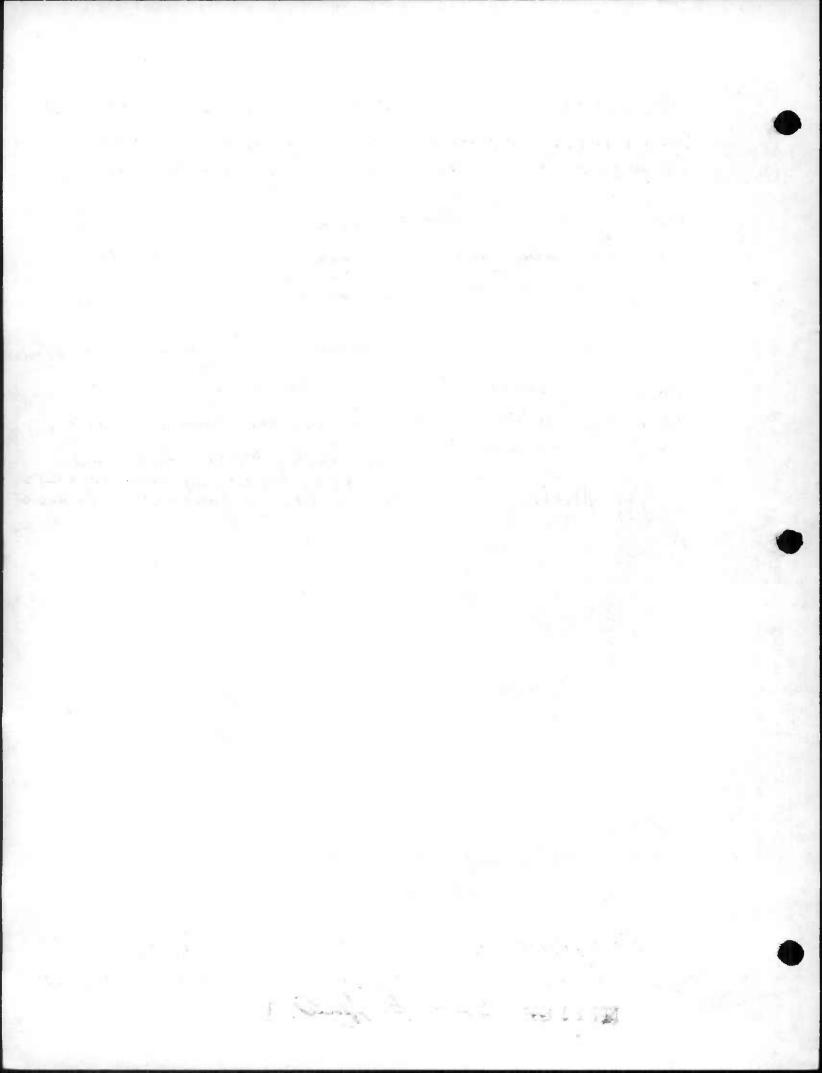
30. Name and addrass of purson who completed causa of death (Item 23a) (Type, Print)

31. Date filad (Month, Day, Year)

32. Registrar's Signatura

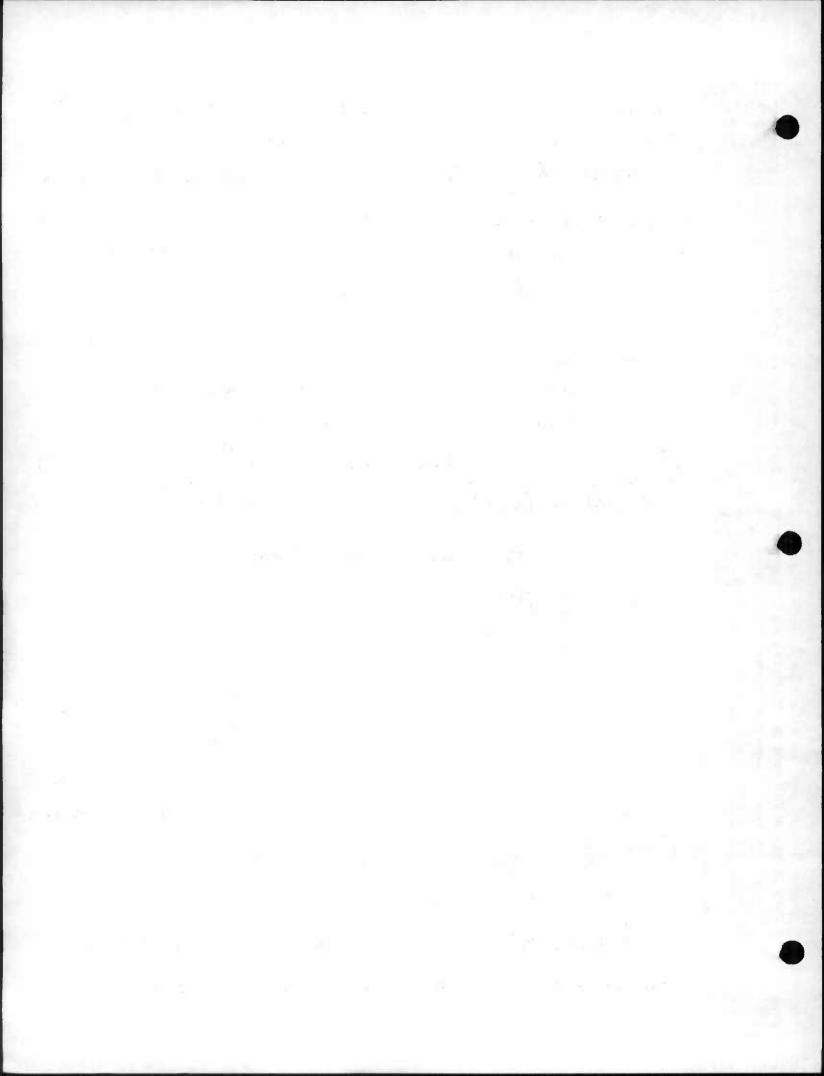
South Greene Street Baltimore, Nd. 21201

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 | 288

						Certificate of	f Death	В	eg. No.		
П	Division		1. Decedant's Nama (First, Middle, Las	t)				2. Data of Dear	th Day	Voor	3. Time of Death
	Physici /Medi		RAYMOND			TAFT		APRIL	20 1	998	10-2 m
	Examir		4a. Facility Name (If not institution, give	street end number)			4b. City, Town, or L		4c. County	of Death	
			Stella Man.	2 H0261	ce		Timoni	um	Bal	tin	rore
Г	Funeral		5. Social Sacurity Number 6. S	ax 7. Age	(In yrs. last b	Months Day:		8. Data of Birth (Month, Day	Year)	9. Birthp	laca (Stata or Foreign
1	Director		000111011	X 201	16	Yrs.		oct. 2	1921	Neu	
	and w		Usual Rasidance of Dacedant 10a, Stata 10b. County	900	10c. City, Toy	vn or Location				1	0d. Insida City Limits
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	the 28a	Director	Maryland Balt	11/01/0		10f. Zip Coda		1	0g. Citizan of V	Vhat Coun	- / '
	be filed within 72 hours efter death with the Maryland ial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Med cal Examination and principal and an extending an ext	Ī	768 Fullbrook	82		2.12			(5 6	1
	ins 2;	Funeral	11. Marital Stetus	12. Was Decedant E	ver in U.S.	13. Was Decedent of		pecify Yas or No-	14. Rac	e - Americ	an Indian.
0	r Her	F	1 □ Navar Marriad 2 Marriad	Armed Forces? 1 ⊠Yas 2 □ No If Yas, Give	0	If Yas, specify Cu	ban, Maxican, Puarte	o Ricen, atc.)	Blac	k, Whita,	atc.
21215-0020	urs e	by	3 Widowad 4 Divorced	If Yas, Give Yaar or Datas: V	IIWV	1□ Yas 2□No	Spacify:		Specify	(u)	hite
2-0	"netural",	ted	15. Dacedant's Ed	ucation	166	a. Decedent's Usual Occi		tuin -	16b. Kind of Bu	siness/inc	lustry
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	filed within Hygiene. there then but, the M	000	12			Broke	2			0	
nd	be filed ital Hygi d other event,	Be	17. Father's Nema (First, Middle, Last)				18. Mother's Nem	ne (First, Middle, I	Maiden Sumem	a)	
yla		P	John Taft	-			Rose	DRUCK	rene		
Maryland	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Ralationship (7	ype, Print)		b. Mailing Address (Street			-		
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Baltimore,			20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐	Ramoval from Stata	cemete	of Disposition (Nama of ary, cramatory or other pi	(ace)	April	20c. Location -	City or To	wn, Stata
‡	permit. Page: Department of Important: If it any injury or once.		4 ☐ Donetlon 5 ☐ Other (Spacify)	Par	Kwood	1	23,1998	Parki	11/18	MD
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7	/Medical Examiner		Immediata Cause (Finel diseasa or condition	· Hmy of	no pluc	consequence of):	Sclerosi	S			
П	LAGITITIE	J	resulting in death)	0	ua to (or as a	consequanca of):				i	
_	be sit	Examiner		b. generali	zed 1	vealiness				1	
	icete be executed physician and s the buriel-transit	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or Injury		ua to (or as a	consequence of):					
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68760,	death certificete be executed e ettending physician and rd for use as the buriel-transit	edicai	rasulting in daath) Last	D	ue to (or as a	consaquance of):					
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0	the che	Physician/	Part II. Other significant conditione co	niributing to death but	not rasulting	in the undariying ceusa g	givan in Part I.				the cause of death?
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Records,	requires i	요 D						24a. Was a			ara autopsy findings
00		let						perform	nad?	cor	ailabla prior to npletion of cause daath?
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Vital			25. Was cese rafarred to madical				OS Diseaset Day	1 Y	/-	11	Yes 200 No
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on	Attending I r death. ector: After by the fune	atio	1. Netural 5 ☐ Panding 2 ☐ Accident invastigation	(Month, Day	Year)		ork? □Yas 2□No				
Division	after death. Director: A	Hice	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, f	arm, straat, factory, office	•	28f. Location (St		er or Rura	I Route Number,
Ö	s after N Direction	Certification:	4 Horilloida	building, etc.	(Specify)			City or Town	i, Stera)		
DC _a	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifiar 1 Certifying Phy	alclan: To the best of	my knowledg	e, deeth occurred et tha t	tima, data and place,	and due to the co	euse(s) end ma	nnar as st	ated.
	the H in 24 the Fi	edicai	one) 2 madical Exam	and mennar state	ad.	nd/or invastigation, in my	opinion, daath occur	rred at tha tima, d	ata and piece, e	end due to	the ceuse(s)
	with To t	Σ	29b. Signatura and the of certifiar	119			nse number	2	9d. Dete signed		
			Calvara	8 Inco		8	44128	70	April	2/54	98
	9		30. Name end eddrass of parson who c	ompleted cause of dea	eth (Item 23a)	(Type, Print)					
			DR. PENELOPE EL	WARDS 230	O DULA	NEY VALLEY	RD. TIMO	NIUM, MD	21093		
	Sta		31. Date filed (Month, Day, Year) APR 23 19	32. Ragitara	s Sign ature	n-Randell					
	Registr	ar	ALU 79 13	98 Juli	in handay	Marinero					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** M9 508 WISC Joseph P 04 98 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good SameritANT Hospital Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) 5. Social Sacurity Number If Under 1 Yaar 9. Birthplaca (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1.8 M 2□ F 215096223 38 Yrs. **Director** JAN 28 1910 Usuel Residence of Decadent with the Maryland 10a. State 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haelih and Mental Hygiena.
Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show mit injury or other traumatic event, the Medical Exercises must be restlined as 10b. County 10d. Inside City Limits MD Lutherville 1 ☐ Yes 2 ☐ No Director BALTO. CO. 10e. Street and Number 10q. Citizen of Whet Country? 10f. Zip Coda USA 201 Castle town RD 21093 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, 11 Marital Status Black. White, etc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 YEARS College (1-4or 5+) MECHANIC KENNICOTT COPPER 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) UNK NOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 201 CASTLETOWN RD. TIMONIUM, MD. 21093 MR. RONALD WISE 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State STANISLAUS CEMETERY 4-22 BALTO. MD. 4 Donation 5 Other (Specify) Ature of Funeral Service License KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. Part I. Enter the diseasa, or com shock, or heart feilure. List only field. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediate Cause (Final Congestive heart Failure disaase or condition resulting in death) Due to (or as a consequenca of): Examiner ischemic CardiomyupaThy attending physician and for use es the bunal-transit Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. that the death certificate be Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown metastatic renal cell Carcinoma by 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to completion of causa of death? Completed 1 Yes 2No 1 ☐ Yes 2 ☐ No Lot Mending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Yo 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tyes 2 No 2 ☐ Accident 3 ☐ Suicida 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the within 2 To the 29c. Licensa number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier , D 51778

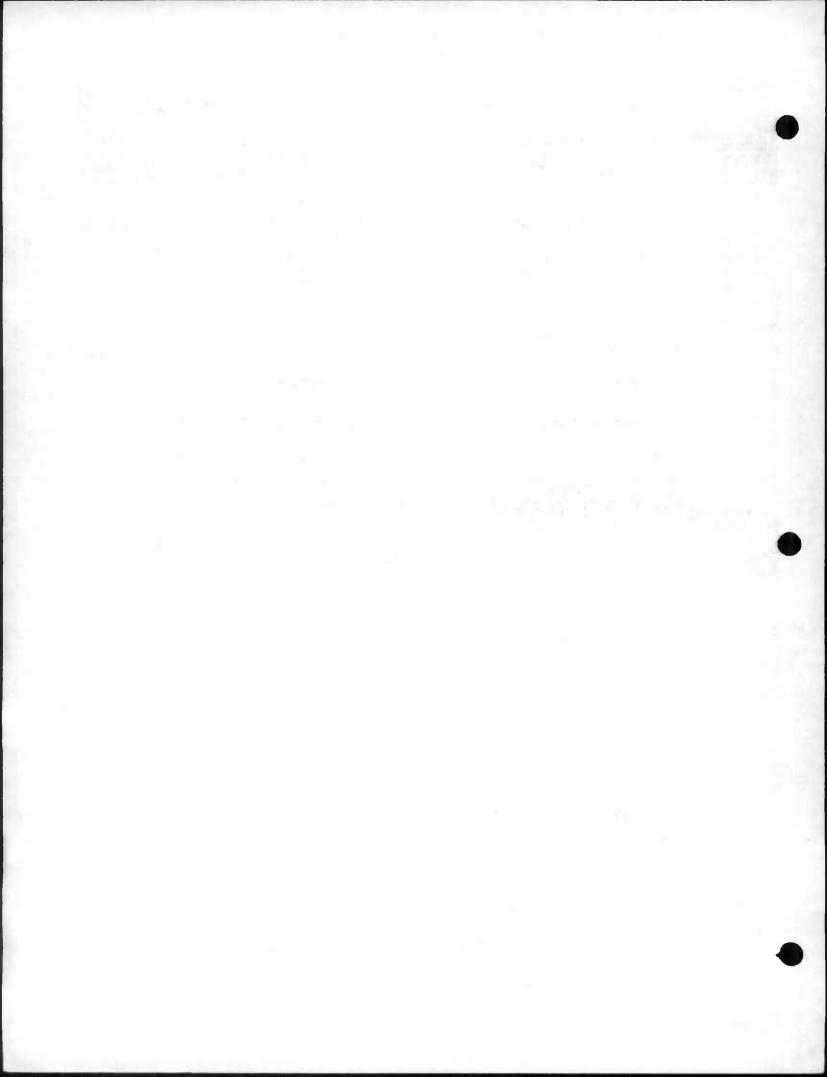
State Registrar 31. Dete filed (Month, Dey, Yeer)

SEGAL MD 5601 Look Raven Slovel.

1998 Julie Davidson-Tandale

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

21239



98-2180-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AM State of Maryland / Department of Health and Mental Hygiene BENJAMIN Items: 23 part I,27,28a-f per MEO G-758 4/20estificate of Death WILLIAMS 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** BENJAMIN APRIL 19,1998 4:18 P /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL ER BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthpleca (Stata or Foraign Country) **Funeral** Months 10M 2DF 44 62-6585 216 Director Usual Residenca of Decedent the Manyland 10c. City, Town or Location 10e Stete 10b County 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at Yas 2 No BAITIMORE Director Larylono 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Street DALLAS USA 238 1205 21213 Funeral deeth 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Yaer or Dates: Hame 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Reca - American Indian 11. Meritel Status Bleck, White, etc. pernit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic avent, the Mexical Estan Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0020 Specify: Aq. 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) PrivAte Elementary/Secondary (0-12) College (1-4or 5+) DINTER BUSINESS 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) VILGINIA M. WilliAms CHARLES Willie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BOITIMUR, LINUS DRIVE SISTER Glean 6308 WILLEHENION 20b. Pieca of Disposition (Neme of cametery, crematory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Ramovei from State 4 Donation 5 Other (Specify) MEMORIAL GORDAN

22. Name end Addrass of Fecility C

3240 REISTERS HATMAN Homis 21. Signature of Funeral Service Licensee 240 REISTENSTOWN / DAD BALDIMOTE ALL STATE
enter the mode of dying, such es cardiac or respiretory errest, 23a Part I Frier the disease, or complications that caused the deeth. Do not enter shoot, or hear nature. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Fine) NARCOTIC INTOXICATION diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner certificate be axecuted physician end the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Physician/Medical Dua to (or as a consaquance of) 80 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 42 Unknown 1 Yes 2 No by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed has 1 Yas Yes 2□ No 2 No or Attending Physician: eftar death. Director: After this certific funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 10 1XXYes 2 No 1 ☐ inpatient 2 XER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred 1 Naturel fourldury 5 Pending 1 Yes 2 X No Unknown investigation 2 Accident found 4/19/98 3:35 6 X Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1221 N. DALLAS ST. 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found in house

Division of Vital Records, P.O. 24 hours e To the F

> State Registrar

completely

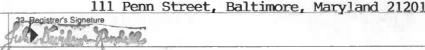
Medical

THEONOREMIKING 31. Dete filed (Month, Dey, Year)

29b. Signatura and title of certifian

29a. Certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete end pleca, end due to the ceuse(s) end menner es stated.

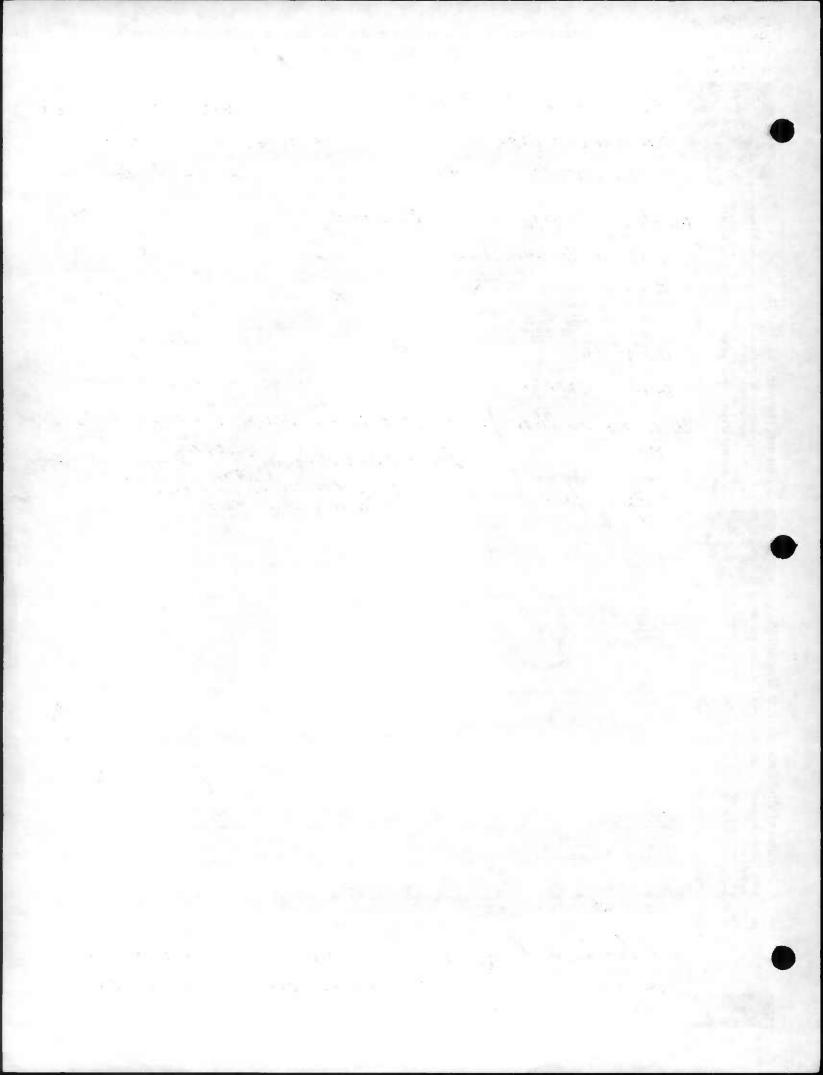
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) end menner steted.

29c. License number

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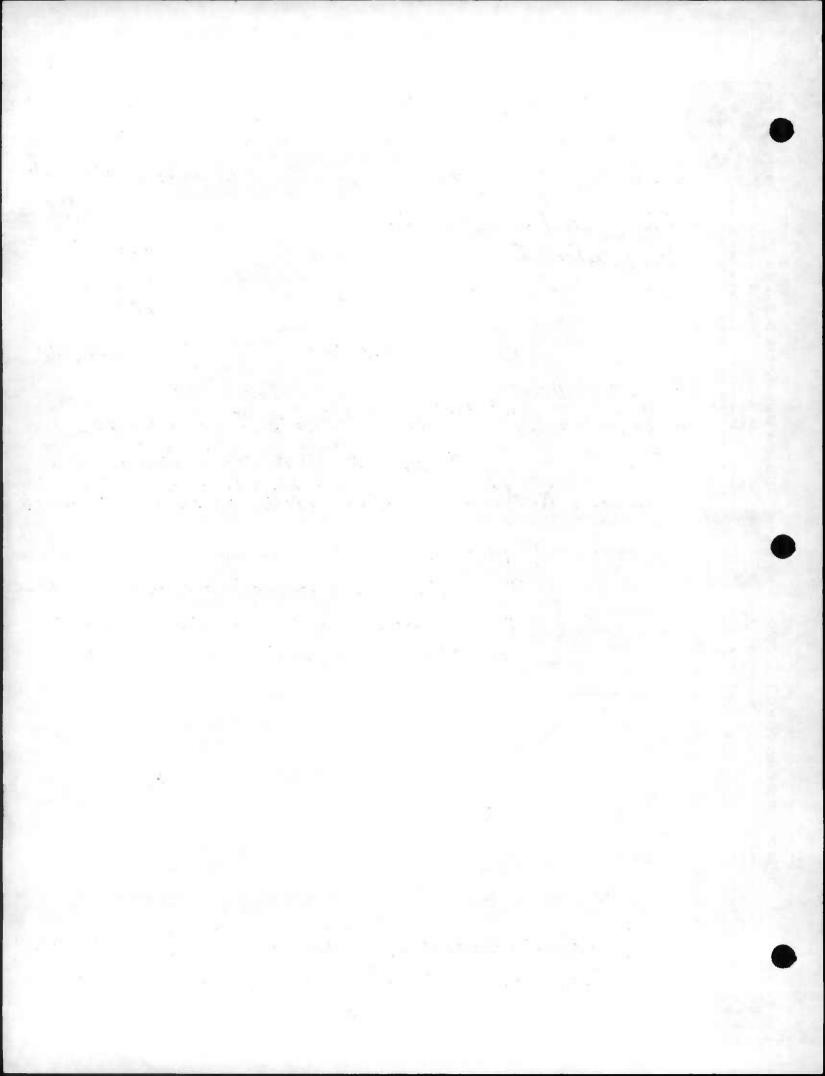
29d. Date signed (Month, Day, Year)

APRIL 20, 1998



State of Maryland / Department of Health and Mental Hygiene

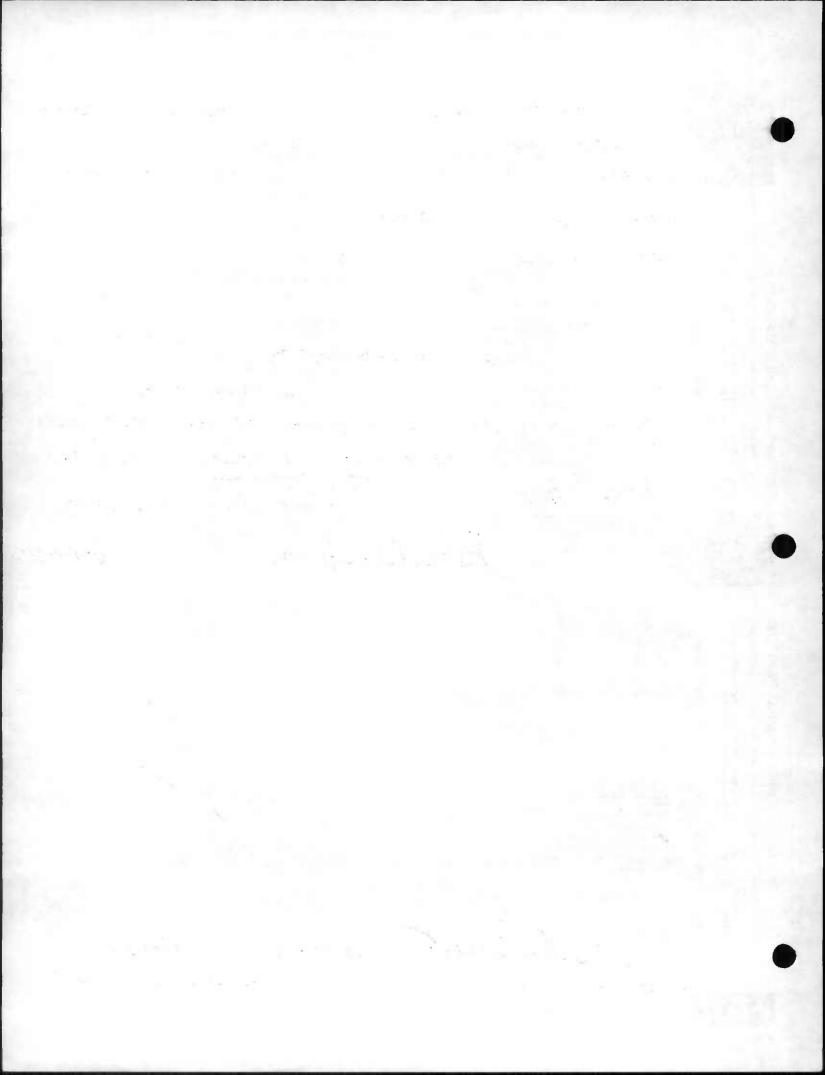
				Certific	ate of Death	R	eg. No.	120	171
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	Examiner	4e Facility Neme (If not institution, giv			4b. City, Town, of	Location of Deeth	4c. County of	Death	
		BONSECOU	IRS HOS	PITAL	13941	More	MI	7	
	Funeral Director	5. Social Security Number 6. S	7. Age (In	yrs. lest birthday) Worn	nder 1 Year II Under 28 Hn his Days Hours Min		Year) 957	Birthplace ((Steteror Foreign
	Maryland of show fied at	10e. Stete / 10b. County /	100	: CityoTown or Location				10d. In	nside City Limits
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	de Ea de	11. Merital Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13. Wes D	ecedent of Hispanic Origin? (specify Cuben, Mexican, Pue	Specify Yes or No- no Rican, etc.)	14. Flace -	American Inc White, etc.	dan,
5-0020	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		s 20 No Specify:		Am	ICAN OrICA	n
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and	ental H ksd ott ic ever	1/11 /1 M /1	neton		121	1/	- C I C		
Maryland	3≥22 F	19a. informent's Name/Relatjonship (Tyba Paul MAThau	19b. Mailing Add		10 Hu	City or Town, St	ete. Zip Cod	ie)
Ma	alth end 27 is m r traum	Mrs la Ruo Hrme	tond	110NCO	Atral/1110 ART	130 Fimore	11 1	12 00	7
e,	f Hear other	20e. Method of Disposition		Ob. Plece of Disposition cemetery, cremetery	Name of		20c. Location - Ci	ty or Town, S	Stete
Baltimore,	nit. Page vartment o ortant: If I injury or	1 ☐ Suriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Jestern S	tar Cem.	4/27/98	Battin	orei	nd-
3ali	permit. Pa Departmen Important: eny injury once.	21. Signature of Funeral Service Liger	00	26. Nam	e end Kddrests of Facility	(fune	ral Hor	ne,	
	20300	posepho	- 7 CUSS	223	2 w. North	ave Bu	Himore	Md.	21216
	Physician	23a Part Enter the disease, or com shock, or heart failure. List only	olications that caused the one cause on each line.	deeth. Do not enter the	mode of dying, such as cerdia	ac or respiratory en	est,	Inter	oroximete orvel Between set end Deeth
23	/Medical	fmmediete Ceuse (Finel diseese or condition	Puln	nomary	Hemork	age		Fa	in Hours
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P.0	es that the death cer igned by the ettendir be detached for use by Physician/I					1 D Y	'es 2□No 3	☐ Probably	4 Unknown
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Division of Vital Records	The law requires the sate has been signed, page 2 should be d					24e. Wes e		evelleble	eutopsy findings le prior to stion of cause
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VIII.	Physician: The this certificate rai director, pagent To Be Co	examiner?	Hospital:		Other	eath (Check only or			
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n	Affer fune	27. Manner of Deeth 1. Naturel 5 Pending investigation	28e. Dete of Injury (Month, Dey Yea	28b. Time of Injury	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	280. Describe in	ow injury occurred		
S	tal or Attending P rs after death. al Director: After ti ed in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		At home, ferm, street, fe		28f. Location (S	treet and Number	or Rurel Rou	ute Number,
Div	after Dire	4 Homicide	building, etc. (Sp	pecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Tow	n, Stete)		
	To the Hospital or Attending I within 24 hours after deals of the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certifier Certifying Ph			red at the time, date and place				
	the Hospit in 24 hour the Funera ppletely fill		end menner stated.	immetion end/or investige	tion, in my opinion, death occ				
	Within To t	29b. Signature and thie of certifier	++ 10		29c. License number	1	29d. Dete signed	The same of the same of	
	h-	1 XIS Vana	nThakeu	na.	D42510		April .	23101.	1998
	7	30. Neme and address of person who		(Item 23e) (Type, Print)		4 1	11)) 10	22/
		31. Dete filed (Month) Pay, Year)	KUM AR,		UTAWST.	# 407	1 10(1	. 210	
	State	31. Dete filed (Months Per Year)	32. Register's S	100	.00				



State of Maryland / Department of Health and Mental Hygiene 8 2892

						Ce	runcai	e or	Death			Reg. No.				
		1. Decedent's Name (First, Middle, Last)								2. Date of De	3. Time of Death					
Physicia		ELEANOR BERTHA INGE ADELONG								April						
/Medica Examine		4a Facility Name (If not insti				DELOIN	7		4b. City, To	wn, or Lo	cation of Death		unty of Dea	2:05 PM		
	51	4322 Walth							Rol+	imore			BT / A			
		5. Social Security Number	6. Se		. Age (In yrs.	last birthdey)	If Unde	r 1 Year	If Under	24 Hrs.	8. Dete of Birt	th	N/A	thplace (State or Foreign		
Funeral Director		218-03-7355		□M 2XF	70	70 Yrs.		Days	Hours	Min.	8. Dete of Bird (Month, Da	y, Year)	C	Country)		
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fand		10a. Stete 10b. Co	unty		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits		
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d within 72 hours efter jlene. r than "naturel", or fte	ΥF	1 Never Married 2		If Yes, Give	1 Yes 2 No							Sp	Specify: White			
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72 net	ete	15. Deci (Specify only h	15. Decedent's Educ (Specify only highest grade			16a. Dece (Give	16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired)							Business/Industry		
within iene.	DE I	Elementery/Secondary (0-	12)	College (1-	for 5+)							Civi	vice			
od v	S.	2 yrs Supervisor:Legal Dept Assistant														
d 2 should be filed the new Mentel Hygi Is marked other traumatic svent, I	Be	17. Father's Name (First, Middle, Last)														
should and Men marke umatic	2	Jessie Walker Inge Nora Elizabeth M									Miln	lilner				
0 0 0 5		19a. Informant's Name/Rela	tionship (T)	ype, Print)		19b. Meili	ing Address	s (Street	and Numb	er or Rura	/ Route Number	er, City or T	own, State,	State, Zip Code)		
1 end 2 Health sm 27 l		Mr. Philip J.	Harr	ris (gra	ndson)	4322	Waltl	her.	Avenu	e, Ba	altimor	e, Ma	ryland	1 21214		
of He		20a. Method of Disposition				lace of Dispo	osition (Ne	me of	ce)		Date	20c. Local	tion - City or	Town, State		
nemit. Peges 1 er Pepartment of Hea mportant: if itsm: iny injury or other		1 A Buriai 2 ☐ Cremai 4 ☐ Donation 5 ☐ Othe								dns4	/23/98	Timon	ium. I	Maryland		
permit. Peges 1 end Department of Health Important: If Itsm 27 any injury or other to	-	21. Signature of Funeral Ser	-						ss of Facili				,			
permit. Departr Importa sny inje		Marla N	Mitchell-Winderfold Home													
	_	Martin D.	Laws	son			5500	York	Road	, Ba	Ltimore	, Mar	yland.	21212		
4.4		shock, or heart failure.	List only o	ne cause on ea	used the deat ch line.	n. Do not en	ter the mod	ae or ayır	ng, such as	cardiac c	r respiratory a	rrest,		Approximate tnterval Between Onset and Deeth		
Physician /Medical Examiner	Martin D. Lawson Martin D. Lawson 6500 York Road, Baltimore, Maryla and State of the Maryla and Stat										Oriset and Deetil					
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requires that the death certificete be executed een signed by the ettending physician end hould be deteched for use as the bunel-trensit	edical	that initiated events resulting in death) Last		Due to (or es e consequence of):								I				
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that the death co	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of deeth?					
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hya hya		4 1 V 0 1 N-	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											ecify)		
D 60	2	1 ☐ Yes 2 No		28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							occurred					
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anding F seth. or: After he funer	⊢	27. Manner of Death Naturel 5 Pe	vestigation	(MONIT			М	1 🗆	Yes 2	No						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 2155 leybuy /Medical 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, give street end number) 4c. County of Death Examiner rundel tospital BUCKE 6 len If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Nov. 29, 1949 Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10XM 2□ F Months Days Hours Min. 48 Director 479-64-6374 Towa Usual Rasidanca of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Insida City Limits must be notified at Director 1 ☐ Yas 2 No Anne Arundel Ft. Meade 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 1850-1 Cain Circle 20755 Funeral death State 1 12. Was Decedant Evar in U,S. Armed Forcas? 1 XYas 2 ☐ No If Yas, Giva 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Navar Married 2 🕅 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White by 3 Widowad 4 Divorced Yaar or Datas: Be Completed 15. Decadant's Education (Specify only highast grade completed) 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantery/Secondary (0-12) College (1-4or 5+) 12 Sergeant First Class US Army 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Seman Earl Atterbury 2 Betty White 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 豊 Department of Health a Important: If item 27 is any injury or other tra Marilyn L. Atterbury - Wife 1850-1 Cain Circle, Ft. Meade, MD 20755 20a. Mathod of Disposition Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Arlington National Cem. 4/30 Arlington, Virginia 21. Signature of Funeral Sarvica Licenses 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 23a. Part1. Entar tha disars or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory strest, Approximately 1.1. Control on the causad the death. Do not antar the mode of dying, such as cardiac or respiratory strest, Approximately 1.1. Control on the causad the death. Do not antar the mode of dying, such as cardiac or respiratory strest, and the causad the death. Approximata fntarval Batweer Onsat and Death Physician /Medical Arrhythmia Immadiata Causa (Final disaasa or condition rasulting in death) MINUtes Examiner Dua to (or as e consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be axecuted tha burial-transit Sequantially list conditions, if any, laading to immediate cause. Entar Undarlying Cause (Disease or injury that initiolad avants rasulting in daath) Last and Dua to (or as a consequence of): Records, P.O. Box 68760. Dua to (or as a consequanca of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? sete has been signed by page 2 should be detact 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior fo complation of cause of death? Completed 24a. Was an autopsy performed? this certificete 1 Yas 2 NO 1 ☐ Yas 2 ☐ No Division of Vital funeral director. Be 25. Was casa referred to medical axeminar? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Daath 28a. Dete of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be dataminad 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide filled 24 hours 29a Certifier 1 Certifying Phyefcfan: To the best of my knowladga, death occurred at tha time, date end place, end dua to tha causa(s) and manner es steted. Medicai Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. To the within 2 29b. Signatura and titla of cartifiae

use of death (Item 23e) (Type, Print)

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32. Registrar's Signatura

State Registrar

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30. Nama and address of person who

31. Data filad (Month, Dey, Year)

DHMH 16 Ray 6/95

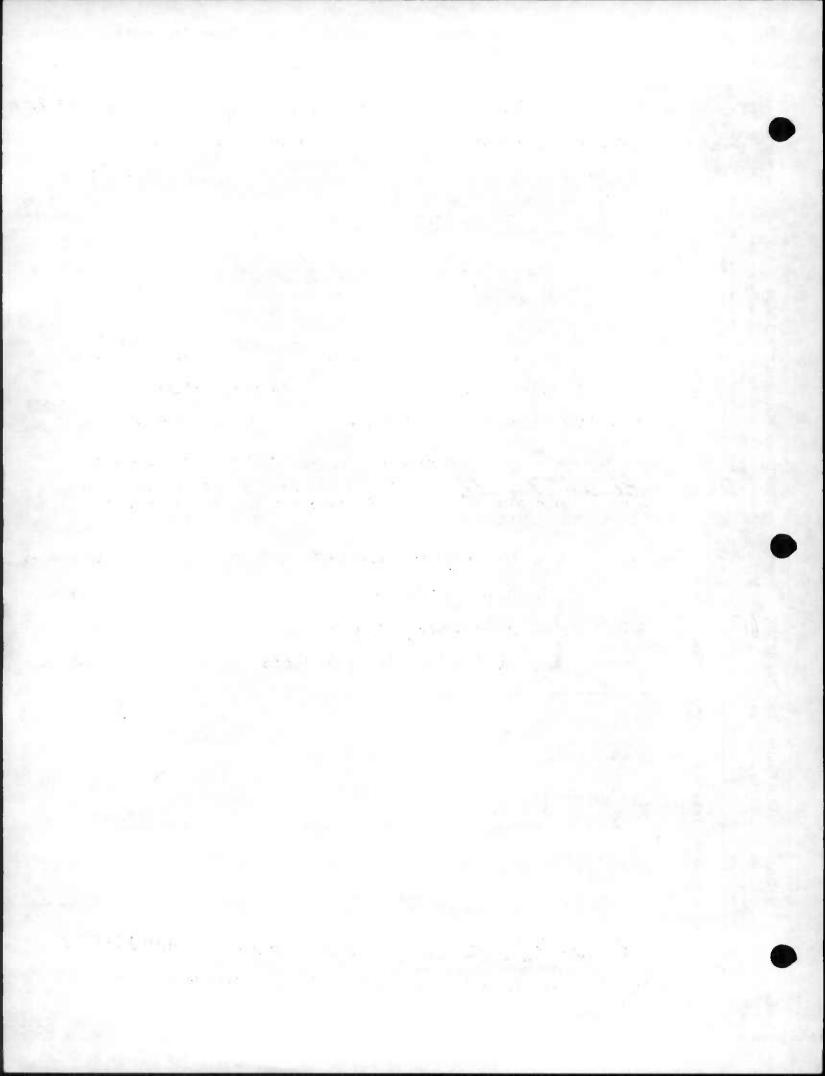
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Lest) 2. Data of Death 3. Time of Death Allen, Jr. **Physician** John 4b. City, Town, or Location of Death 10:42 am 22 1998 /Medical 4c. County of Death 4a Facility Name (If not institution, give straat and number) Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Undar 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 10XM 20 F Yrs. **Director** 043-26-8689 64 NOV 22, 1933 California Usual Rasidance of Decedant with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Wedical Examiner must be notified at FL 1 Yes 2 No Palm Beach Highland Beach Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2701 South Ocean Blvd., 33487 #13 USA Funeral deeth 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours efter I ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 Nevar Married 2 Married "naturel", or i 1 ☐ Yas 2 No Spacify: specify: White p 3 Widowed 4 Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) National Elementary/Secondary (0-12) Collaga (1-4or 5+) Salesman Bisquit Company Is marked other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked ofth any Injury or other traumatic event onthe 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) John E. Allen, Sr. Barbara Pultorak 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 33487 Julia M. Allen/spouse 2701 South Ocean Blvd. #13 Highland Beach, FL 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 04/23/98 Baltimore, MD 22. Nama and Addrass of Fecility
Cremation Society of Maryland, Inc. Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) aryngeal unknown Examiner Dua to (or as a consequence of) Physician/Medical Examiner UNKNOWA ng physician and as the buriel-transit Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury that lighted exercises) law requires that the death certificate began Division of Vital Records, P.O. Box 68760, ettending physician week monary that initiated avants rasulting in daath) Last 1trative process 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was en autopsy performed? Completed peen completion of cause of death? page 2 certificate has The 2 No Physician: 25. Wes case rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA I Director: After this After this 27. Menner of Death 1 Denatural 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: or Attending 5 Panding invastigation 1 Yas 2 No deeth. 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) liffed in by efter 4 Homicida To the Hospital within 24 hours e 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Cartifian (Check only 29d. Date signed (Month, Day, Year)
April 23 1998 29b. Signatura and titla of certifiar 29c. Licansa number RES - 0000 30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print) Brenda P. Smith, mo, Johns Hopkins Hospital, Baltimore, Maryland 21205

32. Ragistralis Signature.

State Registrar 31. Data filad (Month, Day, Year)

APR 24 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Baylor Catherine Elizabeth 18, 98 April 5:13am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 200 Months Hours 51 Director 217-54-2790 05-01-46 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "netural", or items 23s or 28s-f show eny injury or other traumatic event, the Nepical Examinat must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. inside City Limits XXX Yes 2□No MD NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1660 E. Belvedere Avenue 21239 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. 1 ☐ Yas 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Good Samaritan Hosp Nursing Assistant 18. Mother'a Name (First, Middle, Maiden Sumema) 17. Fether's Name (First, Middle, Last) Be Robert Anderson White Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21239 1660 E. Belvedere Avenue Baltimore, MD. Daniel Baylor 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Ramoval from Stata King Mem. Pk. Cem. 04-24-98 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 lence WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final atheroscieratic Cardiovusiular diseuse · Hypertensive disaasa or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner buriel-transit pue Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequanca of): physicles Division of Vital Records, P.O. Box 68760 Physician/Medical the Due to (or as a consequenca of): 83 usa 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed Aheumatic Fever completion of cause of deeth? paga 2 has 1 Yes 20 No 1 ☐ Yes 2 No certificate or Attending Physician: director 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 1XYes 2 No this 28a. Date of Injury (Month, Dey Year) funeral 28c. injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Netural 5 Pending eftar death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide filled in 24 hours Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OCME

111 Penn Street, Baltimore, Maryland 21201

APRIL 22, 1998

State Registrar 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

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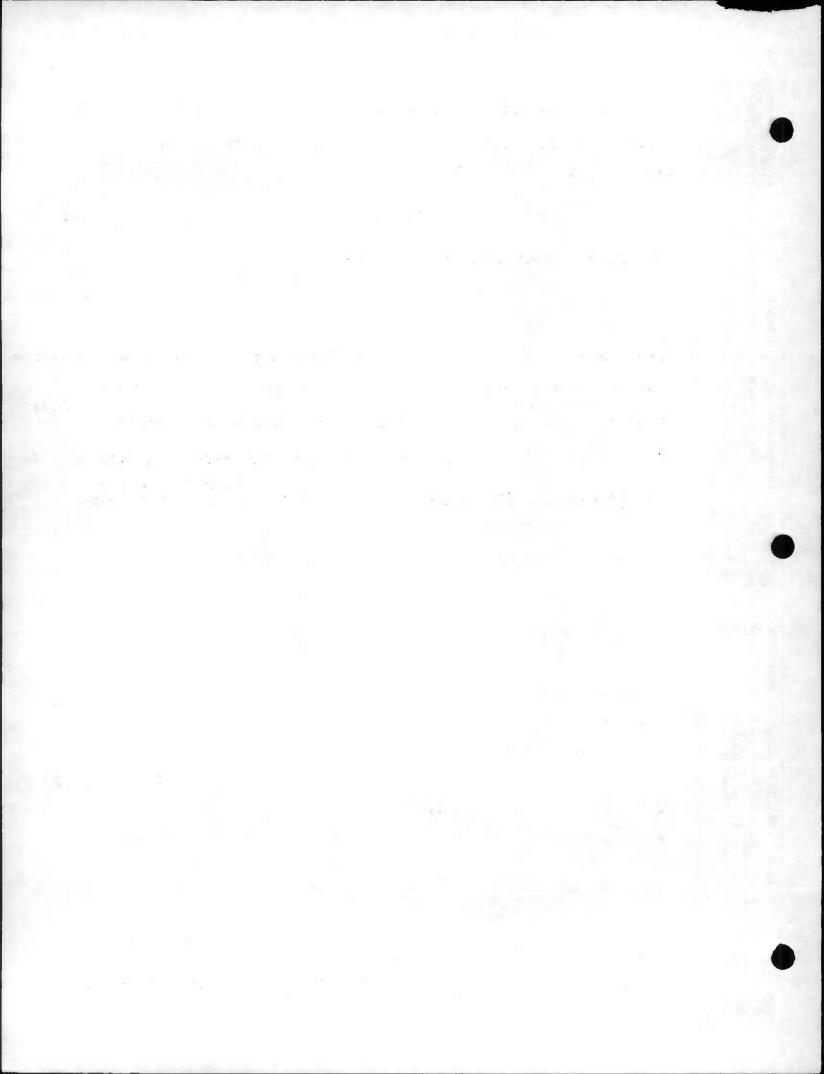
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32. Registry Signaling

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APR 2 4 1998

Stephen



State of Maryland / Department of Health and Mental Hygiene

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	Physic	ian	1. Decedant's Nama (First, Middla, Last)							2. Data of Do	Month Day Yaar			e of Death	
	/Medi		JULIA	BROWN					Hpril		20, 1998 081				
	Exami	ner	Deaton University of MD. Medicine Baltime												
	Funeral Director		5. Social Security Number 6.	Sax 7. Age		last birthday)	If Undar 1	Yaar If	Undar 24 Hrs.					ita or Foreign	
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	or death with the Meryle tems 23a or 28a-1 shore net must be notified at	to	MARYLAND N/A			E	BALTIM	ORE C	ITY					ras 2 □ No	
		Director	10e. Street and Number 10f. Zip Coda 10g. Citizen of What C								What Cou	ntry?			
		ai	22 S. ATHOL AVENUE 21216						U.S.A.						
		Funerai	11. Marital Status	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas;		.S. 13. Was Decedant of Hispanic Origin? If Yas, specify Cuban, Maxicen, Put			nle Origin? (Spe axicen, Puarto	ecify Yas or Ne Rican, atc.)	0- 14. Rad Blad	B. Race - American Indian, Black, Whita, atc.			
020	rs eft	by F	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced				□ Yas 2	XX Sp	pecify:	Specify:			BLACK		
-0	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Menylend Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Introordant: If them 77 is merked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, If a Medical Examiner must be notified at once.		15. Decedent's E	ducation	on mp(storf)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of wor lifa. DO NOT use ratired)			'	usinass/industry				
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7		S	7th grade WRAPPING DEPT. HEC 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan S								ECHT CO.				
an		To Be	JAMES H. POWELL	/					LIZABET						
ary		-	19a. Informant's Name/Ralationship	(Type, Print)		19b. Mailin	g Address (Street and	Number or Run	al Routa Numb	per, City or Town,	m, Stata, Zip Code)			
Σ			Dorothy I. Jacks	on/Sister		771 (QUeens	town	Rd., Se	evern,	Maryland	1 211	44		
ore	t of H If Item or oth		20a. Mathod of Disposition XXX Burial 2 □ Cramation 3 [Ramoval from Stata		lace of Dispo ematary, cran				Data	20c. Location				
<u>=</u>	it. Pa rtmen rtant: njury		4 Donation 5 Other (Special		BAL	TIMORE					BALTIMO				
Ba	Depar Impor any ir		21. Signatura of Funeral Sarvice Licensea 22. Nama and Addrass of Facility ILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE										F/H		
	Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death												
			immediata Causa (Final disaasa or condition rasulting in daath) a. Uny o S ch S is Due to (or as a consequence of):									1	5	Layo	
			rasulting in daath)	a	Due to (o	r as a conseq	uance of):							days.	
	bet ns.t	Examiner		b. Mul.	top	ewer	md	2.					40	oks.	
Ċ.	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and ral director, page 2 should be detached for use as the burfel-transit		Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause Disease or Injury that initiated events Due to (or as a consequence of):									İ			
68760.		edicai	Causa (Diseasa or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of):												
9 ×		Physician/Med													
Box			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contrib										- 40		
Ö		hys	gg to down put not receiving it the underlying octors given in Fall I.								Yes 2□ No				
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ords			24a. Was an au performed?									24b. Wara autopsy findings available prior to completion of cause			
J-Z	S 55 CA	Completed										of	daath?	or cause	
UU al Re	Physician: The law this certificate has ral director, page 2	To Be									Yes 2 No	1[☐ Yas	22 No	
_ <u>\</u> \ \	Physician: this certific											6.1			
	g Phy er this		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tima of Injury Work? 28c. Injury at Work?							у)				
∑ Sior	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	atio	1 Natural 5 Panding 2 Accident Invastigation	M 1 Yas 2 N											
Division		Certification:	3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)							28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)					
آ ۵		Medical Ce	29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.											sa(s)	
			29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Mo D 3 4 97 4.								d (Month,	Day, Yes	ır)		
	,)														
13	4		30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 58 65, Robert oliver place, # 121, (6 lumbia, MD 21045												
		ate	31. Data filed (Month, Day, Year)			ura wasan-l									
	Regist	rar	APR 2.4	1998	may W	10/4000V-1	milanoc								

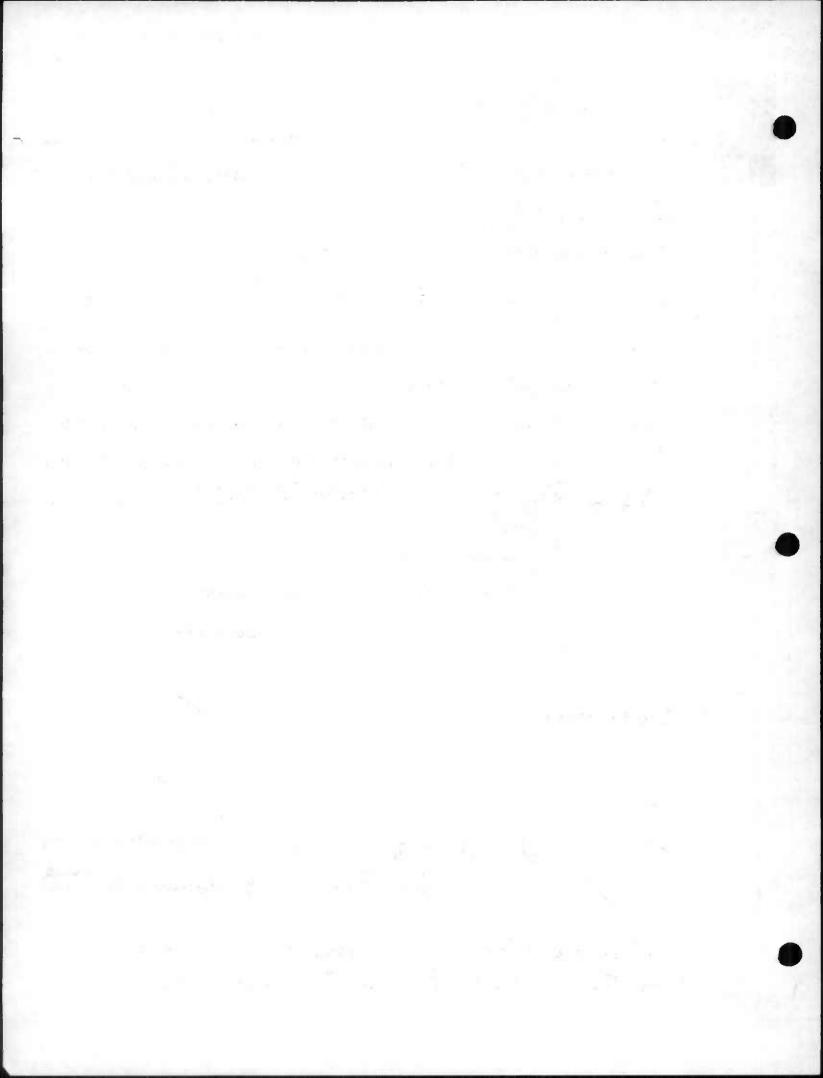
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						Cer	tificate of	Deatl	h	F	Reg. No.		
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	xamin		4e. Fecility Neme (If not institution, g 1832 BYRD STREE)				Own, or Local IMORE	ation of Deeth		of Deeth	1
	neral ector		5. Social Security Number 6. 220-36-5645	Sex 7. A	ge (In yrs. lasi 55	birthday) Yrs.	If Under 1 Year Months Deys			8. Date of Birt (Month, De)	v, Year)	9. Birthp Cour Nort	olece (State or Foreign otry) Ch Caroli
9			Usuel Residence of Decedent							000.2	0,17.4		
deeth with the Marylend	notified at	tor	Md. 10b. County		10c. City, T	own or Loc		timo	re			1	Od. Inside City Limits Yes 2 □ No
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th with	untbe	0	1832 Byrd St	reet				2123	0			USA	
- je =	SXIII	by Funeral Director	11. Marital Status 1 ☐ Never Merried 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 2 Yes 2 ☐ If Yes, Give Yeer or Dates:	Ever in U,S. No 196	3 13. W	/es Decedent of Yes, specify Cul			cify Yes or No- tican, etc.)	14. Rec Bled	ck, White,	wan Indien, etc.
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within within then "	N N	Completed	Elementery/Segondary (0-12)	College (1-4or	5+)	16e. Decedent's Usual Occupetion (Give kind of work done during most of life. DO NOT use retired) Computer Opera					Cemi	cal	Company
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Maryland d 2 should be file th end Mentel Hy 7 is marked other	amn.		19e. Informent's Neme/Reletionship	(Type, Print)		19b. Melling	Address (Stree	t end Num	ber or Rural	Route Numbe	r, City or Town,	Stete, Zip	Code)
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0 % 5	r oth		20e. Method of Disposition 1 Buriel 2 Cremetlon 3	Bamaual from State		of Dispos	ition (Neme of etory or other ple	ece)		Dete	20c. Location -	City or To	own, State
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Ball Permit. Depart			A Donetion 5 Other (Specify) Maryland Veterans Cem 4/17 Crownsville 21. Signeture of Funerel Service Licensee Stallings Funeral Home PA 311 Mountain Rd. Pasadena, Md. 2										
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Geath death	of be	sician	Pert II. Other eignificent conditions	contributing to death b	out not resultin	a in the une	derivina cause a	iven in Peri		23b. Did t	obacco use co	ntribute to	the cause of death?
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一方の	ed in by th	Certification:	3 Suicide 6 Could not to determine determined	20e. Piece of in	jury - At home c. (Specify)	ferm, stree	et, factory, offica	For	21	8f. Location (S City or Tow	itreet and Numb m, Stete)	er or Rure	Our Number,
T Pour	etely fiil	- 1	29a. Certifier (Check only one) 1	nysicien: To the best miner: On the besis o end manner st	f exeminetion	ige, death o end/or inve	occurred et the to estigetion, in my	me, date e opinion, de	and plece, er	nd due to the d	euse(s) end ma date end plece,	nner es si end due to	teted. the ceuse(s)
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State Registrar



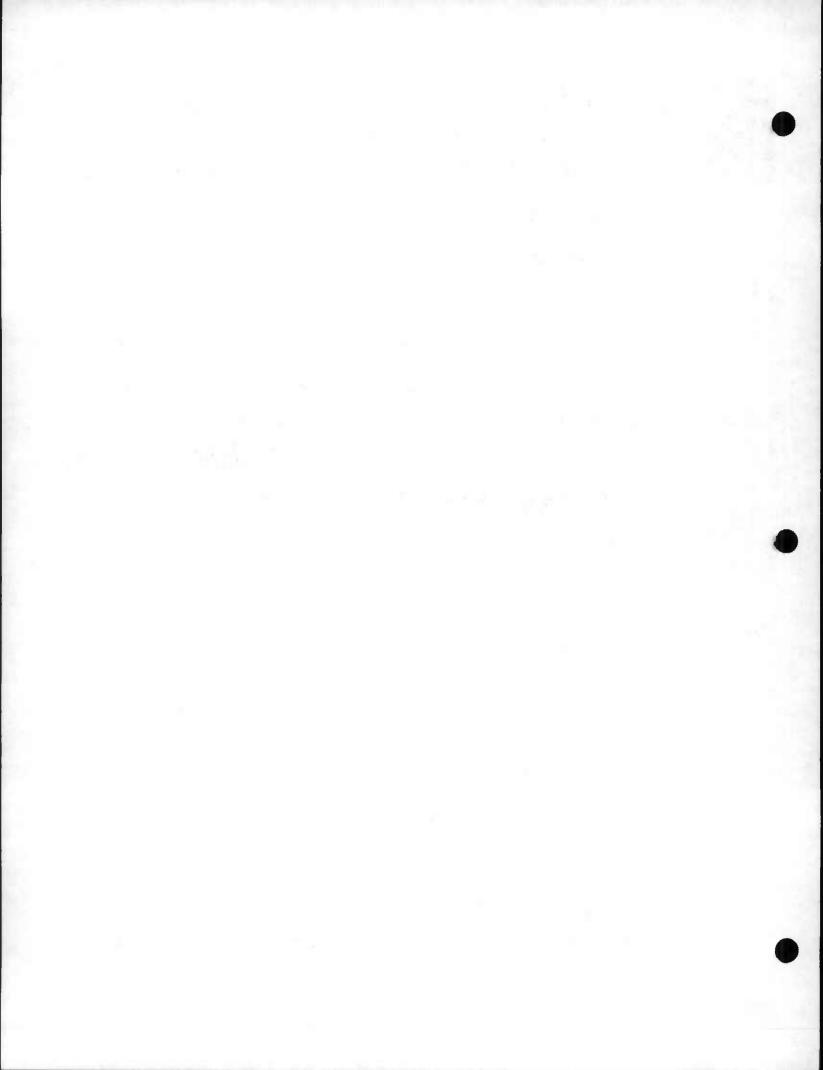
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 0420A EMMETT BUTTON **WITITIAM** 4PRIL 23 1998 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist Center if Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) July 21, 1908 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1 XM 2 ☐ F Yrs. Md. **Director** 212-10-1338 Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21040 297 Winterberry Dr. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiena. Wher than "naturel", or Ite 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married imore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry American Smelting & Elementary/Secondary (0-12) College (1-4or 5+) Cost Accountant Refining 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Heelth end Mentel Rehbein Annie Button 2 Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) . nt of Heeith e 297 Winterberry Dr. Edgewood, Md. 21040 Mrs. Marilyn Elliott/daughter 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4/27/98 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Ferranal Se 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Ancyto penia
Due to (or as a consequence of): month disease or condition resulting in deeth) Examiner YS ears Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of deeth? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, Attending Physicien: 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 28e. Date of Injury (Month, Day Year) 28c. fnjury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending i or Attendin after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or 124 hours after
 Funeral Directory filled in bietaly filled in b Medical 29e. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end menner as stated. To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number (ciley, mo cause of death (Item 23a) (Type, Print) 30. Neme end eddress of person who co N. Charles St. Balto md 2120) 6701 39. Registrar's Signature 31. Date filed (Month, Day, Year) APR 24 1998 fandell. Registrar

and purchase from 180 - and

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death Month **Physician** SARAL BLUESTEIN April 22 525 A. /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County HUSD. HOWARD Gen. COLUMBIA If Under 24 Hrs. HOWARD If Undar 1 Year 5. Social Sacurity Number Data of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1□M 27 F 86 Yrs Director 498-48-9485 Usual Rasidenca of Dec MAY 19, 1911 MISSOURI the Maryland 10a. Stata 10h County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 25 No Director MISSOURI SAINT LOUIS SAINT LOUIS 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 12023 LAKE MEADE DRIVE U.S.A. Funeral 63146 death 14. Raca - Amarlcan Indien, Black, White, etc. 12. Was Dacedant Evar in U.S. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 11. Marital Status Armad Forcas?

1 Yes 2 No
If Yes, Give filed within 72 hours efter 1 Nevar Marriad 2 Married 1 ☐ Yas 2 No Specify: altimore, Maryland 21215-0020 Specify: WHITE ò 3 DWidowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If I flam 27 is marked other than any injury or other trainment. Elementary/Sacondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be 2 BEN BUDOWSKY FANNIE SPECIER 19a, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 7121 BRADYWINE WAY, COLUMBIA, MARYLAND 21046 H. JACK BLUESTEIN, SON 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3X Ramoval from State UNITED HEBREW CONGREGATION 4/26/18 SPRINGFIELD, MISSOURI 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Signatura of Funeral Sarvica Licansee 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Pert1. Entar tha disease, or complications that caused the death. Do not antar tha mode of dylng, such es cardiac or respiretory errast, shock, or haart failura. List only one cause on each lina. Approximete Intarval Batween Onsat end Death **Physician** /Medical Immediata Causa (Final Obstructive Pulmomy END STAGE CHRONIC diseasa or condition resulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner end Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseese or injury that initiated avants rasulting in daath) Lest Dua to (or as a consequance of) P.O. Box 68760, The law requires thet the death certificete on the Dua to (or as a consequanca of) for signed by the tid be detached Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of causa of death? hes page certificete 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter deeth. 25. Was casa raferred to medical Be 26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funerei 27. Manner of Deeth 28b. Tima of Medicai Certification: 28c. Injury et Work? 28d. Dascribe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accidant **Director**: in by the 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Mospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, daath occurred et the time, deta and place, and dua to tha causa(s) and manner as steted.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) end manner stated. 29a, Certifier (Check only one) 29c. Licansa number 29b. Signatura and the otic 29d. Date signed (Month, Dey, Yaer) D42465 Mo 30. Nama and address of person who complated causa of deeth (Item 23e) (Type, Print) WILLIAM SAWAY 2 Knoll NORTH DV. 31. Data filed (Month, Day, Year) 2. Ragistrar's Signatura
Why Davidson-Gandall State 24 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#10e.19b per+FH G758 4/28/98 EW 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death A Month 115AM Thomas Leo Bergenthuin 23 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c County of Death Gilchrist Center Towson Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) FEB 2, 1928 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1₩ 2□ F 060-34-1371 70 Yrs. Indonesia Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Parkville Baltimore 10f. Zin Code 10c. Citizen of What Country? 10e, Street and Number Autumn Audumn View Way 2432 21234 IJSA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Project Engineer Domino Sugar 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fathar's Name (First, Middla, Last) Thomas Bergenthuin Maria Alida Cornelia Klinkenberg 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Steta, Zip Code) Autumn Audumn View Way Parkville, MD 21234 Silion (Nama of Date 20c. Location - City or Town, State Eugenie G. Gani/wife 20b. Place of Disposition (Nama of cematary, crametory or othar placa) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/24/98 Baltimore, MD 21. Signature Funeral Service Licens 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Approximate interval Between Onset and Death 729orch Gregrochik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final DANCreatic CANCER metastatic disaase or condition resulting in deeth) Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Pages 1 end 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene.

Hygiene.

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permit. Pages 1 end 2: Department of Heelth er Important: If item 27 is any injury or other trau pace.

Baltimore, Maryland 21215-0020

Examiner and Physician/Medicai

þ Completed Be

Certification: To

edical

signed by t d be detect s certificate has b director, page 2 s or Attending Physician: After this certific funerel director, Vihin 24 hours after working to the Funeral Director: A death.

ERGENTHUIN , THO MAS

25. Wes cese referred to medicel examiner? 1 Yes 2 No

27. Manner of Death 5 Pending 1 Natural 2 Accident 3 Suicide

> (Check only one)

6 Could not be datarminad 4 - Homicide 29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) invastigation

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Has joice 28d. Describe how injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated.

29b. Signature and title of pertifier

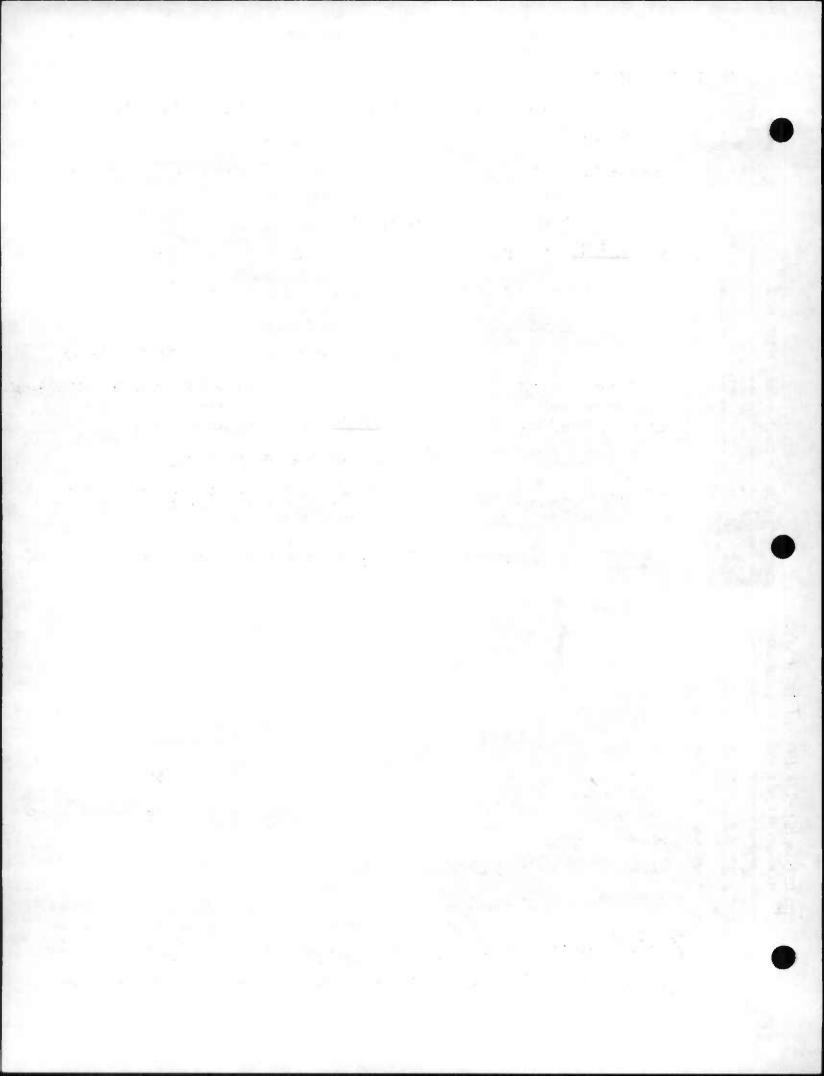
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death from 23a) (Type, Print) N. Charles St. Balto. Md 2120x GBMCG 6701

Registra

32. Registrate Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Yaar MARIE ELIZABETH BRESSLER APRIL 1998 6:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore County 7508 Kenlea Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M XXF Yrs. Director 220-07-4326 August 23,1920 Maryland Usual Residence of Decedent 10a Stata 10h Counts 10c. City, Town or Location 10d. inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Baltimore County Baltimore Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21236 USA 7508 Kenlea Avenue Items 23a 11 Marital Status 12. Was Decedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas XX No Specify: by Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 7 yrs. 17. Fether's Name (First, Middle, Last) Housekeeping-Own Home N/A Housewife 18. Mother's Name (First, Middle, Malden Sumame) Ada Lee Wilson William E. Plitt 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 2819 Topaz Rd. Baltimore, Maryland 21234 Harriett L. Hill 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State Moreland Memorial Park 4-23-98 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one causa on each line. 7401 Belair Rd. Baltimore, Md. 21236 Physician CARCINOMA OF THE LUNG /Medical 6 months Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of):

Congestive heart farifure

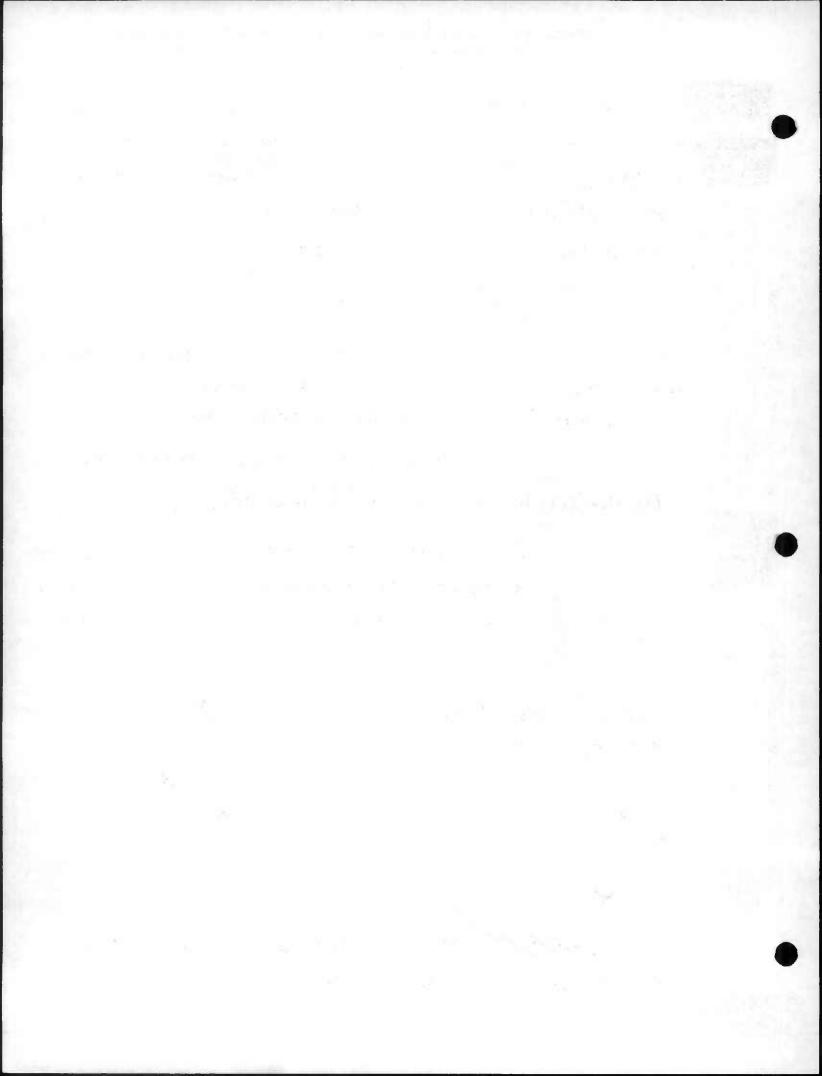
Due to (or as a consequence of):

COR PRIMURATE Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last end attending physician e for use as the buriel-P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Chronic bronchitis 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Emphy sem A Completed 24a. Was en autopsy performed? certificate 1 Yes 2 No Division of Vital lal or Attending Physician: The stiff death.

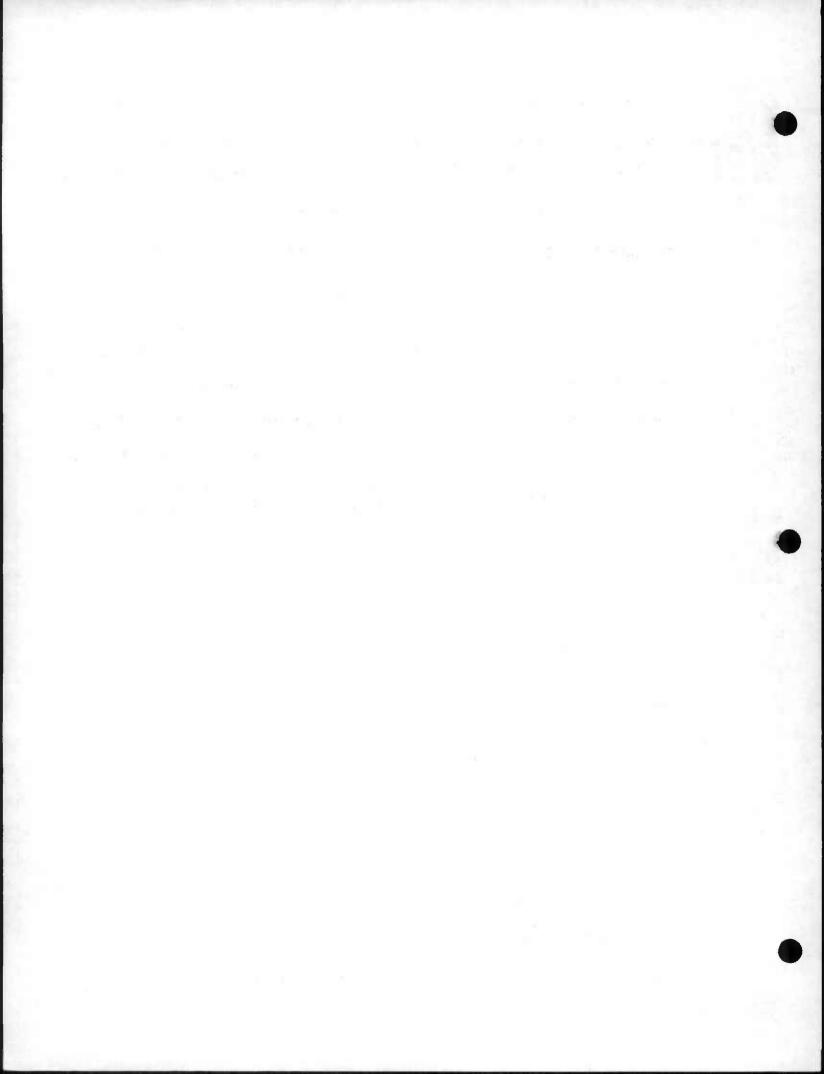
Solution of the physician of 25. Was cese reterred to medicel exeminer?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home St Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Fundal Di completely filled y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

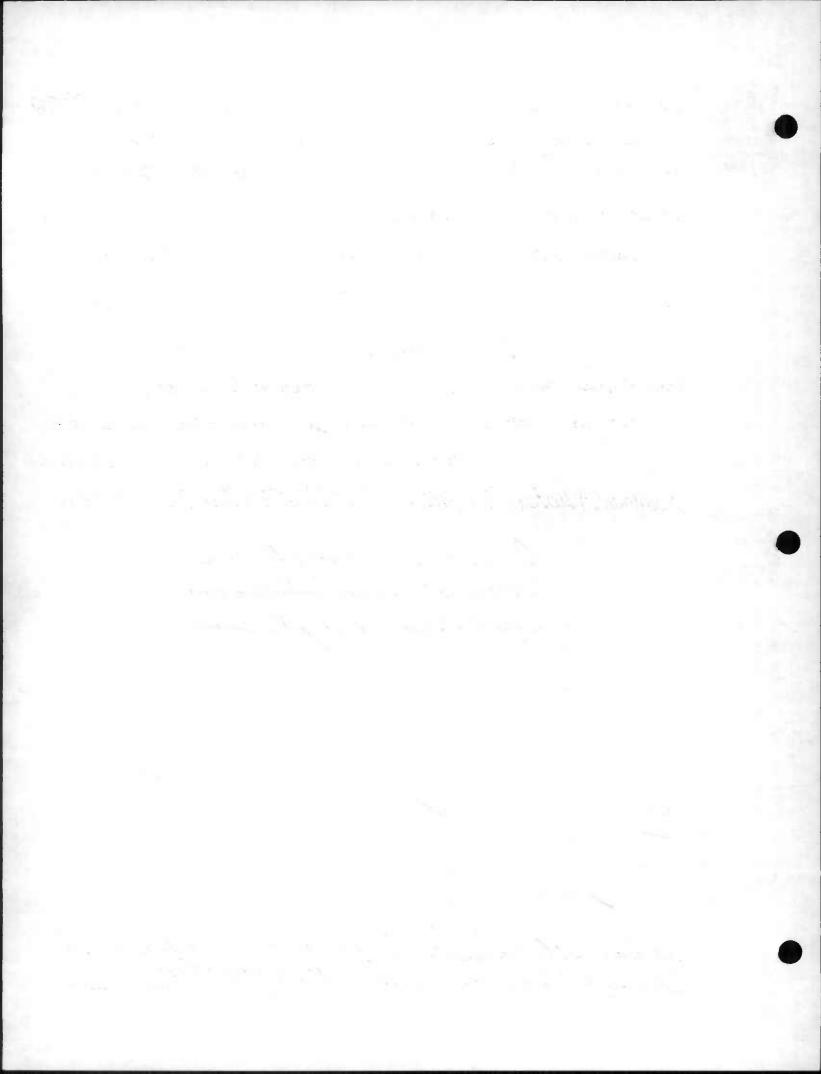
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifian 29d. Date signed (Month, Dey, Year) 29c. License number D16728 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 8010 Belora POND, BATIMURE 21236 , MD CAW-WIN 32 Registrar's Signature State Registrar



		Decedant's Name (First, Mid.	de Last)		Cei	rtificate of	Death	2. Date of De	Reg. No.	1.6	2 Time of Dank		
Physici /Medic		DELPHIA	BRIDGEM	AN				Month Apri	Day	Year 1998	3. Time of Death $12:24P$		
Examir		4a. Facility Neme (If not instituti	on, give street and numb	ber)	31		4b. City, Town, or L	ocation of Deat	h 4c. County	of Deeth			
Funeral Director		Memorial 5. Sociel Security Number 403-12-8708	Hospital 6. Sex 7 1 M 2 F	@ East Age (In yrs. las 81		If Under 1 Year Months Days	Easton, If Under 24 Hrs. Hours Min.	MD 8. Date of Bi (Month, De	rth ay, Year)		ace (Stete or Foreign y)		
		Usual Residence of Decedent						DEC . 24	,1910	vend	tucky		
Maryiar a-f show	tor	Md. Can	oline	10c. City, 1	Town or Lo		nton			10	d. Inside City Limits 1 Yes 2 No		
or 28	Jirec	10e. Street and Number			-	10f. Zip Code			10g. Citizen of	What Countr	ry?		
23e	ral	420 Colonial	Drive				21629		USA				
Department of Health and Mental Hygiene. Important: if item 23e or 28e-f show important: if item 27 is marked other than "natural", or items 23e or 28e-f show stry highly or other traumatic event, the Medical Exercises must be notified at once.	by Funeral Director	11. Marital Stetus 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	If Yes Give	as? CXNo		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☐XNo	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	5- 14. Rec Bla Specif	ca - America ck, White, e y: Whi	tc.		
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Aental rked o	To Be	Duran Flanner	y					e Johns		,			
and Is me		19a, Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	er, City or Town	State, Zlp (Code)		
m 27 her tr		Frank Proctor	^				ye Drive	-					
ment of hant: If its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ca/m	atary, cren	sition (Name of natory or other place of Faith	^{ce)} 4/2	4/98	20c. Location ROSSV		m, Stete Md •		
Depart Import eny In		21. Signatura of Funeral Service	10	ll		Connelly	/ Funeral	Home o	f Essex	201			
hysician		23a. Part1. Entar tha disease, o shock, or heart failure. Lis	t complications that cau	used the death.	not ente	ar the mode of dyir	ng, such as cerdiac	or raspiratory a	rrest,	221	Approximate Intervel Between Onset and Death		
/Medical Examiner		Immediate Cause (Final disease or condition resulting In death)	8	Seps Due to (or as		unnes of h					3wts		
#	iner		(Dreum	-					Į			
physician end s the burial-transit	I Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		Dua to (or as	s a conseq	uence of):							
uearr cermicate be executed e attending physician end od for use es the burial-transit	/Medical	that initiated events resulting in death) Last	d	Due to (or as	a consequ	uence of):							
atten d for u	Iclar	Part II. Other algnificent condit	lone contributing to deat	th hut not rocultin	and the sure	edod dos serves sh	ron la Part I	225 DId	tobooo	neelbrote ee e	the serves of death 0		
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Withir To th	Me	290. Signature and title of certify	6// 1			29c. Licens			29d. Dete signe	d (Month, D	ay, Year)		
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		30. Name and address of persor											
		Jeffrey Do				ox 122	Goldsbo	ro MD	21636				
Sta Registr		31. Data filed (Month, Day, Year	gring D	istrants Signatur	Endelle								



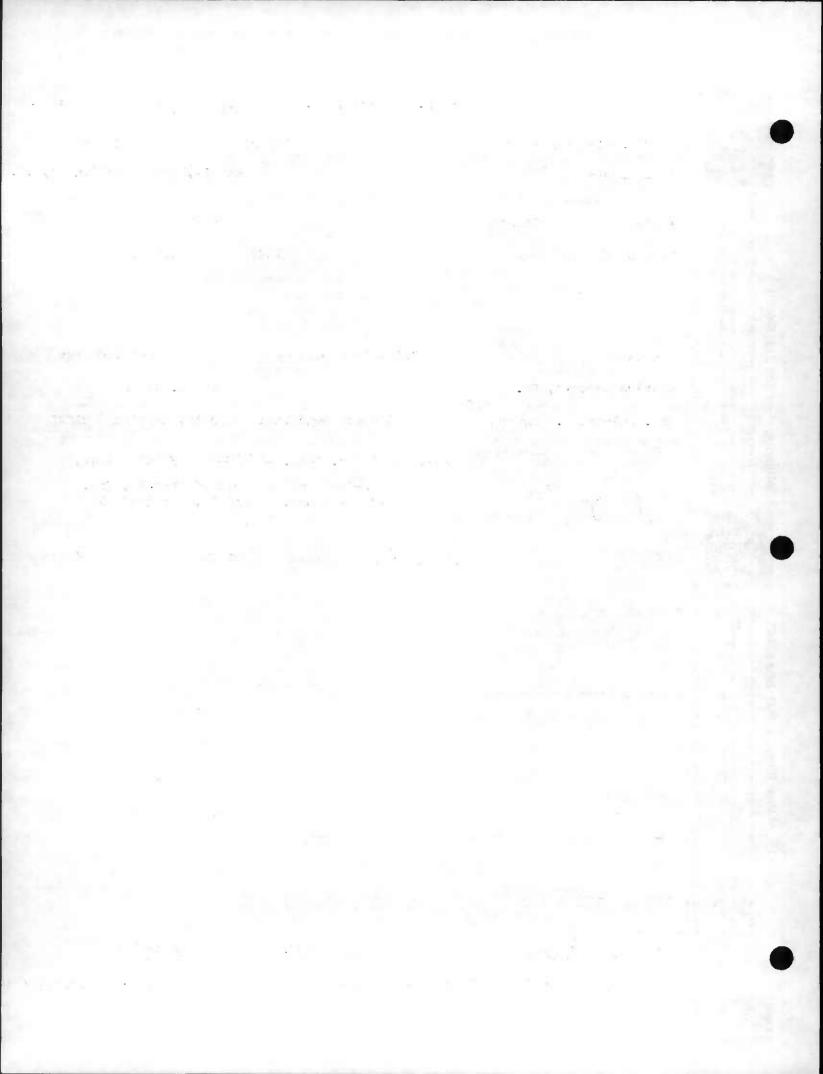
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lend we		10a. Stata 10b. County		10c. City	, Town or Lo	cation				10d. Insi	da City Limits		
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Dan permit Deper Impor any in		21. Signature of Funaral Sarving Licensaa 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212											
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requires that the death certificate signed by the ettending hould be detached for use as	Physician/M												
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tiffica for, F		25. Was casa rafarrad to medical		-tit offi			Other:			ar (Specify)			
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Of VICE Physician: this certific ral director,	2	axaminer? 1	1 ∐ Ing 28a. Date of (Month, n e 28e. Place o	Injury Day Yaar)	28b. Tima of Injury me, farm, str	28c. Ir	njury at Vork?	28d. Dascribe h	ow Injury occurr				
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DIVISION OF VICE September 10 VICE hour are dearly near Officior; After this certific Willed in by the funeral director.	edical Certification: To	axaminer? 1	28a. Date of (Month, nee 28e. Place o building	Injury Day Yaar) Injury - At ho, atc. (Specify est of my know s of examinati	28b. Tima of Injury me, farm, str.)	28c. Ir M 1 aat, factory, office occurred et the	all Nursin Nork? Yas 2 No ce e time, data and pl y opinion, death o	28d. Dascribe h 28f. Location (S City or Tow ece, and due to the occurred at tha tima, o	ow Injury occurr itreet and Numb n, Stata) euse(s) end ma lata and place, s	er or Rural Routa nnar as stated. and dua to tha ca	Number,		
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate o	f Death	7	F	eg. No.		
	Physician /Medical	1. Decedant's Name (First, Midd		harles	L. C	omegys,	Jr.		2. Data of Dee Month April 2	Dey 24, 199	Year 8	3. Time of Death 5:30 AM
N.	Examiner	4a Facility Name (If not institution	n, give street and n	um <i>ber)</i>			4b. City, T	own, or L	ocation of Deeth	4c. County	of Death	
4		7643 South Be	end Road					unda	lk		Balti	more
	Funeral Director	5. Social Security Number 214-20-0521	6. Sax 1½ M 2□ F	7. Aga (In yr: 72	s. last birthday Yrs.	Months Day		Min.	8. Data of Birtl (Month, Day May 14	Year) 1925	9. Birthp Coun Wash	lace (State or Foreign itry) ington, D. C
	p 2	Usual Residence of Dacedant 10a, State 10b, County	,	10c C	ity, Town or L	ocation					1	0d. Inside City Limits
	filed within 72 hours efter death with the Maryland Mysiene. Whysiene then "natural", or items 23a or 28a-f show ont, the Medical Evaniner must be notified at ord. The Medical Evaniner must be notified at example the Mysiene Mysi	1.00.00.00	Baltimon						Dunda			1 ☐ Yas 2 ☑ No
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02	by		If Yas, G Year or	Datas: WV	IIV	ILI TAS ZLAN	o specin	,.		Specit	y:	White
21215-0020	be filed within 72 hours tal Hygiene. d other than "natural", event, I'm Medical Exa Be Completed by	15. Deceda (Specify only highe	nt's Education est grade completed	f)	16a. Dece (Give	edant's Usual Occ e kind of work dor DO NOT use ret	cupation ne during mo ired)	st of work	ding	16b. Kind of B	usiness/Ind	dustry
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/lan	should be fill and Mental H marked out umatic ever	61							Mary	A. Kla	us	
	d 2 sh th and 7 ls m traum	19a. Informant's Name/Relation Mrs. Delores R		Wife		ing Addrass (Stre						21222
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Baltimore,	permit. Pages Department of Important: If it any injury or o	21. Signatura of Funaral Sarvice	Licensea		Î	2. Name and Add Ouda-Ruc	dress of Faci k Fune	ral :	Home of	Dundal	k, In	c.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dele of Death 3. Time of Death Day Month Veer **Physician** George Cross 21, 1998 April 2:20 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 7120 Furnace Branch Road Glen Burnie Anne Arundel If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days M 20 F Months 72 Yrs. 220-12-6987 MAR 9, 1926 Director Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Itam 27 is marked other than "naturel", or Itams 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Anne Arundel Glen Burnie 10e Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 7120 Furnace Branch Road 21060 USA Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces?

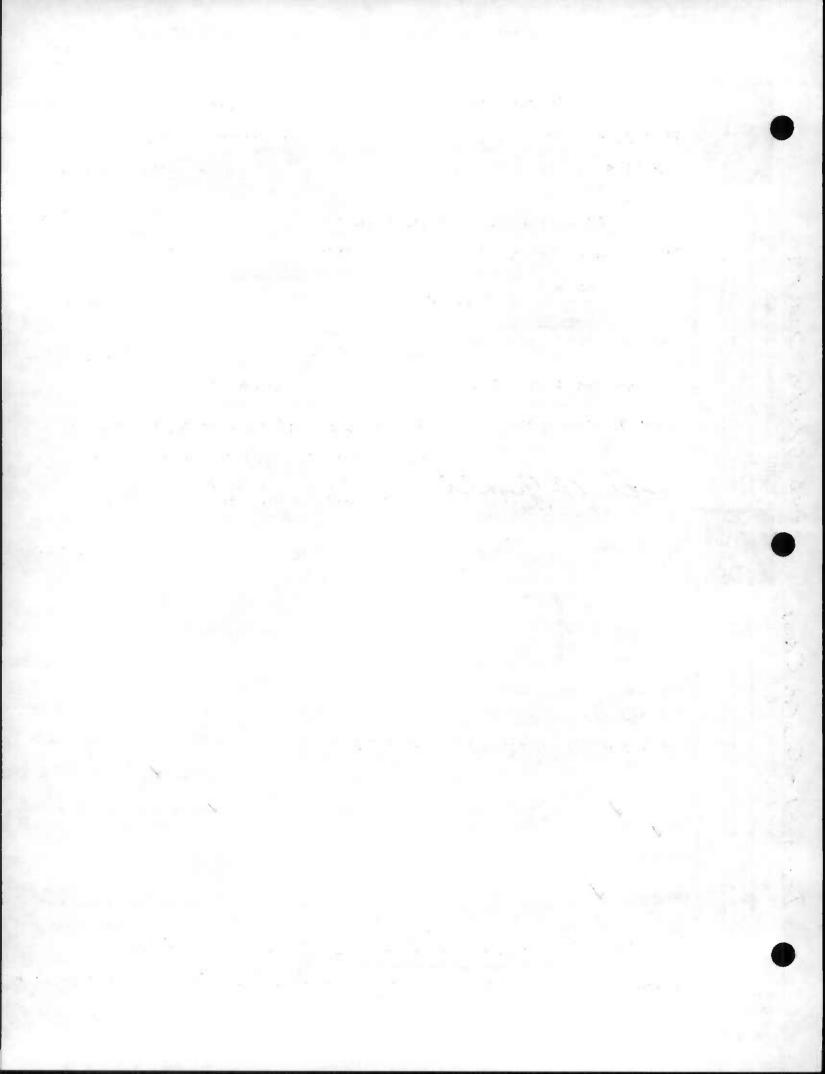
1 X Yes 2 □ No If Yes, Give Yeer or Detes:1944–1970 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca · American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pagas 1 and 2 should be filed within in nent of Haalth and Mantal Hygiane. int: If item 27 is marked other than "s Elementary/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking 200 4/21/98 18. Mother'a Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) George Cross, Sr. Naoma Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2: Department of Health at Important: If Itam 27 fa any Injury or other trau once. Edith L. Cross/Wife 7120 Furnace Branch Rd. Glen Burnie, MD 21060

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Localion - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/22/98 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature Funeral Service Licens Edward A. Crecisions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 Approximate Interval Between Onset and Death **Physician** PROSTATE /Medical 3 YRS Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ettanding physician and for usa as the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or es e consequence of) resulting in death) Last The lew requires that the death 23b. Did tobacco use contributa to the cause of death? ed by tha e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably Dunknown 1 ☐ Yes 2 ☐ No ARTERY DISEASE ò 24b. Were autopsy findings available prior to completion of cause of death? DYSRHYTHMIA (V-FIB) 24a. Was en eutopsy Completed hes 1 Yes 2 No 1 □ Vas 2 □ No cartificete ECEASEd Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 □Other (Specify) 1 Yes 25 No 2 this 28a. Date of Injury (Month, Dey Year) funaral 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After or Attanding s after dash... 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piaca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C complataly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29d. Dele signed (Month, Dey, Year) 29b. Signature and title of certifig 29c. License number D30276 APRIL 22 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FT MITADIE 20755 ARMAUD KIMBROUGH AMBULATORY CARE GR GUILLERMOL M.D. 32. Registraris Signature
Suma Dandson-Randson

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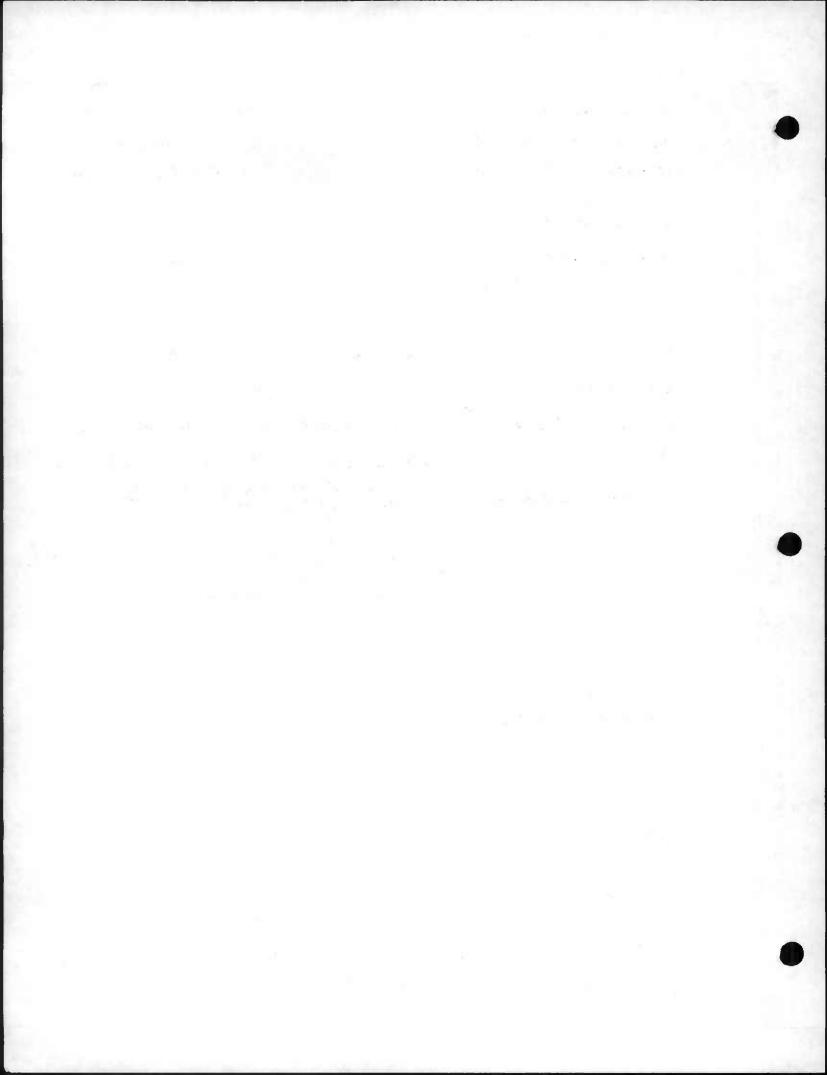
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Dey Month **Physician** April 19, C. LAURA COSGROVE 1998 4:15 p.m. /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford Honder 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Min. Month 4, 1905 5. Social Sacurity Number 9. Birthpleca (Steta or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2以F 216-48-3937 Yrs. Director Usuel Rasidence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. fnside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryla Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is Marolical Examinar must be notlined a 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 718 S. Shamrock Road 21014 U.S.A. Funerai 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 10th grade Homemaker Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles Glackin Laura Pule SON-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 718 S. Shamrock Road, Bel Air, MD. Frederick E. Kuhn, Sr. (law 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriei 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 4/22/98 Bel Air. Maryland 22. Nome and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21 21. Signatura of Funeral Service Licansae Buin a. Willen 21014 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner por respon bunal-trensit physician and s the bunal-trens Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequença of) Box 68760 Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to complation of causa of deeth? Completed 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐Nursing Homa 5☐ Residenca 6☐Other (Specify) funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar 1 - Naturel ie Hospital or Attending in 24 hours after death. he Funeral Director: Afte pletely filled in by the fun-5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Phyelofan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) To the Hospi within 24 hou To the Funer completely fil 29a. Certifier end mannar stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 232255 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 615 WESTMACPHA 5. 31. Dete filad (Month, Day, Yeer) 32. Registras Signatura

Julia Davidson-Randell APR 24 1998

DHMH 16 Rev 6/95

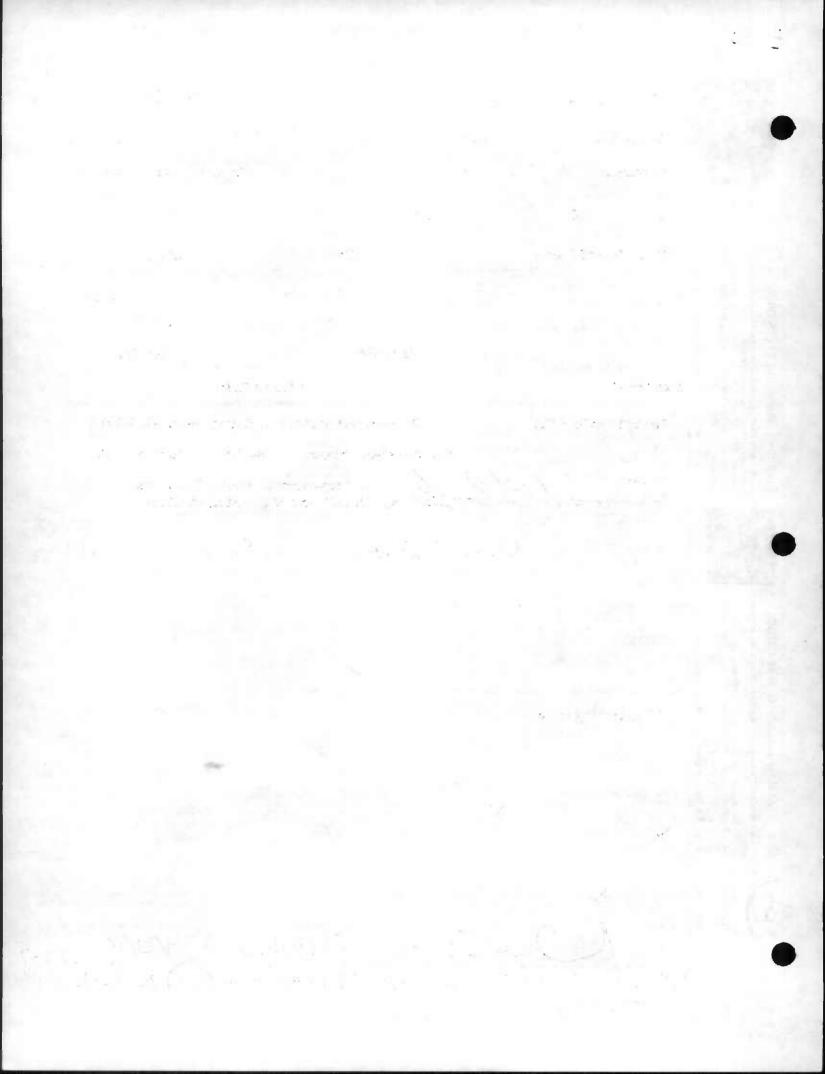


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 545 AM **Physician** Eleanor R /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Baltinor Rosedal Habital JUNGE enter If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 10 M 20 F Hours Director 87 Maryland 217-09-0697 Sept. 16, 1910 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural; or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No N/A Md. Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 420 N. Kenwood Avenue 21224 U.S.A. Funeral 14. Rece - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White p 3M Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First Middle Last) Be 2 Lean Demski Antonina Socka 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Leonard Cydylo / Son 6200 Westchester Park Dr., College Park, Md. 20740 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or once. St. Stanislaus Cemetery 4-24-1998 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Servica Licanse Moran-Ashton-Dabrowski Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Matricture Pulmongy Immediate Cause (Final disease or condition resulting in death) Examiner Examine physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequença of) 80 ettending p signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown ρ should I 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 has 2000 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 10 this Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Affec Attending 1 Natural 2 Accident 5 Pending investigation death 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide 8 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) Neme and address of person who completed cause of death (Item 23e) (Type, Print)

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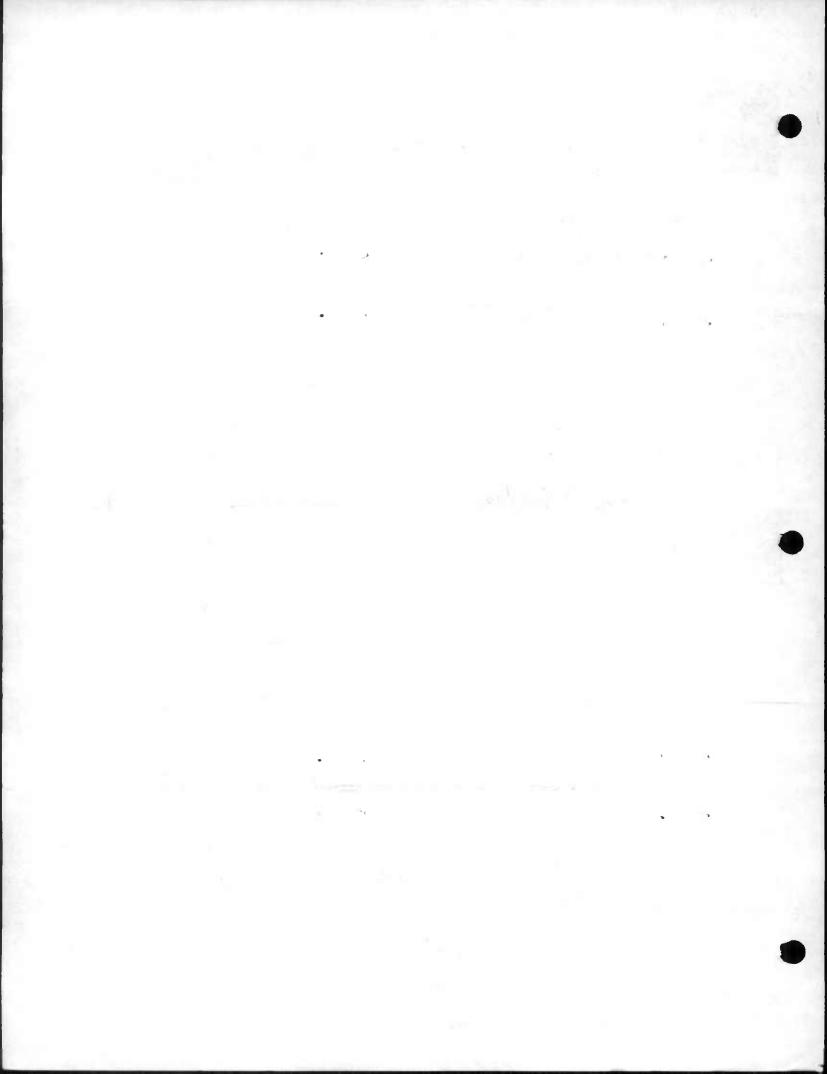
DHMH 16 Rev 6/95

State Registrar 31. Dete



State of Maryland / Department of Health and Mental Hygiene

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/Medic		4a. Facility Name (If not institutio			1 DCC	4b. City, Town, or L		4c. County of De			
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Funeral		JOHNS HOPKINS 5. Social Security Number		GAL CHINTE	(av) If Under 1 Year		8. Date of Birth	1			
Director		161-20-2837 Usual Residence of Decedent	1□M 2□F	Yr	Months Day	Hours Min.	(Month, Day, August	1, 1916	Sirthplace (State or Fore Country) Pi Harrisbi		
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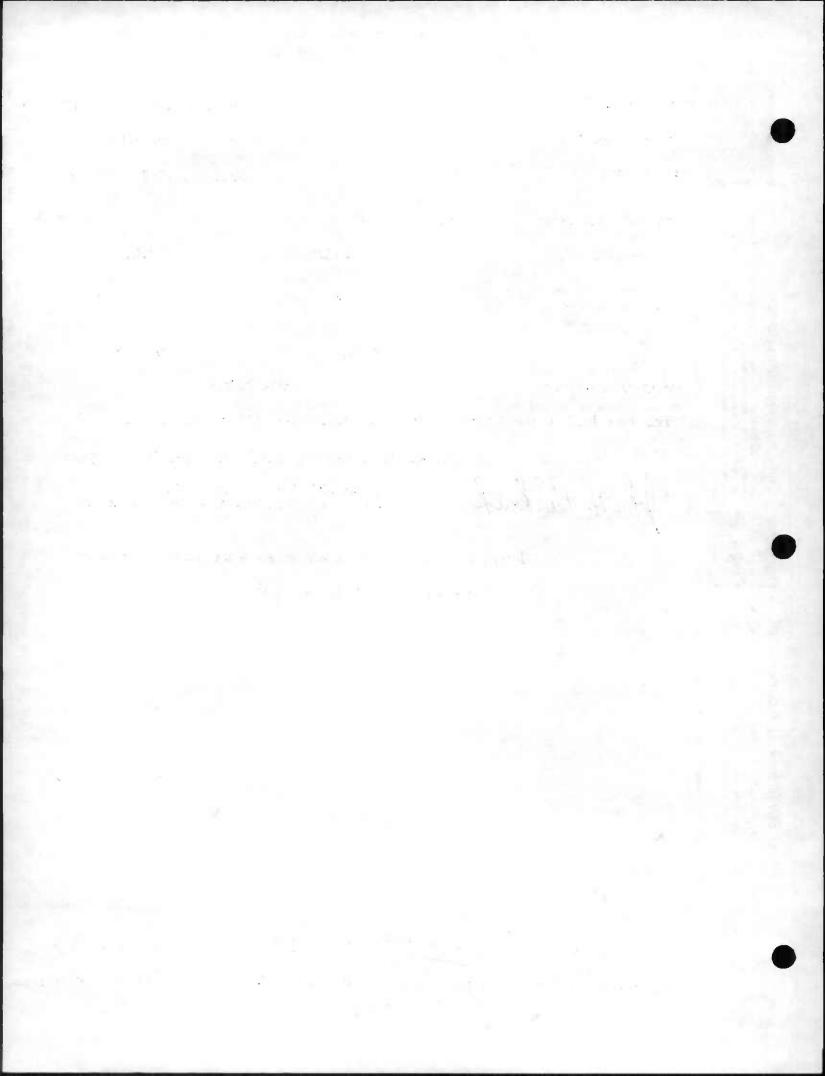
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N	/Medica Examine	_	4a Facility Name (nd number				4b. City, Tow			4c. County		12.10 111
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	Funeral		5. Social Security N		. Sex		ge (In yrs.	lest birthday)	If Under 1 Yea Months Days		4 Hrs. 8. D.	ate of Birth fonth, Dey,	Year)	9. Birthp	place (State or Foraign
п	Director		218-28-4	842	1□ M 20	XF	65	Yrs.	MOINTS Days	Hours			, 1932	0001	Pa.
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21215-0020	within 72 hours efter deeth with the Merylend ene. than "naturat", or frems 23a or 28s-1 show he Medical Evantinet must be notified as	DA La		ied 2 ☑ Marrie	d 1 G	ned Forces Yes 2 x es, Give ar or Datas	? No		If Yas, specify Cui 1 ☐ Yes 2 ☑ No	ban, Mexican,	Puèrto Ricen	, etc.)		ck, White,	
2-0	should be filed within 72 hours ad Mental Hygiene. merked other than "netural", imetic event, the Medical Exe	Completed	/Sna	15. Decedent's	Education	inted)		16a. Dece	dent's Usual Occu	pation	of working		16b. Kind of Bu	usiness/In	dustry
21	e. an	e l	Elemantary/Seco	oify only highest andary (0-12)		lege (1-40)	r 5+)	life.	kind of work done DO NOT use retir	ed)	or worning				
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Maryland	nould be filed within a Mental Hygiene. nerked other than natic event, fre	0	17. Fathar's Nama	(First, Middla, Li	ist)					18. Mother	's Name (Firs	t, Middle, N	Aaiden Sumem	10)	
Z a	should Men	0	Chester	Jose			ting			Mary		J.	Gamo		
Mar	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Relationship)												
	1 end 2 Health em 27 i	-	Mr. William Dorman/husband 20 Old Dominion Ct. C												
Baltimore,	it of H			Cramation	Ramova	from State	е (cemetary, cre	metory or other pl		Da		20c. Location - City or Town, State		
tim	t. Pertment	-		5 ☐ Other (Spe			Dul		alley Me			5/98 Timonium, Md.			
Bal	permit. Peges 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Nem 27 is mericed other than "naturary injury or other traumetic event, the Medical police.		21. Signature of Fi	E C	250	D	>		Ruck Tow	ama and Address of Facility ICK Towson Funeral Home, Inc. O York Rd. Towson, Md. 21204					
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	Physician														Onset and Death
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	-		resulting in death)		a		Dua to (or as a consa	quance of):						
	D # 5				b										
	The law requires that the death certificate be executed at has been signed by the ettending physician and page 2 should be detached for use as the bunk-transit	Xan	Sequentially list co	onditions, nmadiate			Due to (or as a consa	quance of):						
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P.0.	by the tached	3	Part II. Other signi					-		ivan in Part I.		230. Diù to	-		bably 4 Unknown
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5	Physician: this certific ral director,	ן מ	axaminar?		Hospital	: 1 🗆 Inpa	tient 2	ER/Outpatie	nt 3 DOA	thor:			ence 6 Oth	ar (Speci	(fv)
Division of	Phys or this oral di		27. Mannar of Deal		28a.	Date of In (Month, D		28b. Time o			-		ow Injury occur		.,,
lon	Attending or deeth.	0	1 Natural 2 Accident	5 Pending investiga		(Month, L	ay rear)	Injury		Yes 2 N	lo				
N N	After deep octon	2	3 ☐ Suicide 4 ☐ Homicida	6 Could no datamin		Place of I	njury - At h	ome, farm, st	reet, factory, office	B	28f. L	ocation (St	treet end Numb	ber or Rur	ral Route Number,
Ö	tal or Attending P rs efter deeth. el Director: After t led in by the funera	5	4 Hornicida			building, i	etc. (Speci	17)				ony or row	, 0.0.0)		
	To the Hospital or Attending Physician: The I within 24 hours effer deeth. To the Funeral Director: After this certificate his completely filled in by the funeral director, pege	dical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	caminer: On	To tha bes the basis d manner:	of examina	owledga, deat ation and/or in	h occurred at that vastigation, in my	time, data and opinion, death	place, and d	ue to the ca tha tima, d	ausa(s) and ma ata and place,	anner as	stated. to the cause(s)
	ithin o the		29b. Signature and	titie of certifier	11100				29c. Lice	nse number		2	9d. Date signe	d (Month	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) April 21 1998 **Physician** Grace Evelyn Frey 9:25 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Middle River Baltimore 207 Wampler Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 90 Yrs. **Director** 216 20 1011 Aug. 26, 1907 Georgia Usual Residence of Decedent with the Marylend permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event, the Medical Example in the profited page. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Middle River Directo Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 U.S.A. 207 Wampler Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 White 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Tester Aerospace 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lydia Rider Matthew Armstrong 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Shirley Mailalieu (Daughter) 2022 Landsdowne Way Silver Spring Md. 20910 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Bel Air Mem. Gardens 4/24/1998 Bel Air, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 1407 Old Eastern Avenue Esse. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) CARDIOVASCULAR DISEASE · HYPERTENSIVE Examiner Due to (or as a consequence of): Physician/Medical Examiner SENILE DEMENTIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as e consequence of): resulting in death) Lest 23b. Did tobacco use contribute to the cause of deeth? by the e Part Ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that signed t by 24b. Were autopsy findings evalleble prior to should I Completed 24a. Wes en eutopsy performed? completion of cause of deeth? s certificate has b 1 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Certification: or Attending 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hour.
The Funeral Dire Hospital 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated. edical 29e. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 4-22-98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . ZOLI BALLARD AVE , BALTEMORE MOZIZE MADHIRAJU CTOVIND 32. Regi rars Signature State 2 who Davidson

DHMH 16 Rev 6/95



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 Day **Physician** Justine 19.44 Michael Griffin 20 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not Institution, give street end number) 4c. County of Death Examiner Maryland Hospital/22 South Greene/Baltimore University Baltimoe (9. Birthplace Country) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 100 M 2□ F Yrs. NA 04-0498 Director 16 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Mad call Examiner must be notified at Y☐ Yes 2☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21223 death Funeral 2606 Lehman Street 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, etc.) 14 Race - American Indian, Black, White, etc. 72 hours after Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) permit. Pages 1 and 2 should be filed within: Department of Haalth and Mental Hyglena. Important: If Item 27 is marked other than "neny Injury or other traumatic event, I'm Mad College (1-4or 5+) Elementary/Secondary (0-12) Infant Child Infant NA 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumema) Quincie R. Griffin Remus L. Burnett 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2606 Lehman Street. Baltimore, Md 21223 Quincie Griffin 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, cramatory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell Mem. Gardens 04-25-98 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensea 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Pert1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart feiture. List only one ceuse on eech line. Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) a Septic Examiner Sepsis sician and burgi-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Last Syn drome physician s the burlet Box 68760. Physician/Medical rematurit Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Interstitial Emphysema ð 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yea 2 XNo 1 Yes 2 □ No 25. Was cese referred to medical exeminer? 28. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? ne Hospital or Attending P n 24 hours aftar death. Ne Funeral Director: After t After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 29a. Certifier (Check only one) 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad.

29c. Licensa number

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R. Stackmion, M.D.

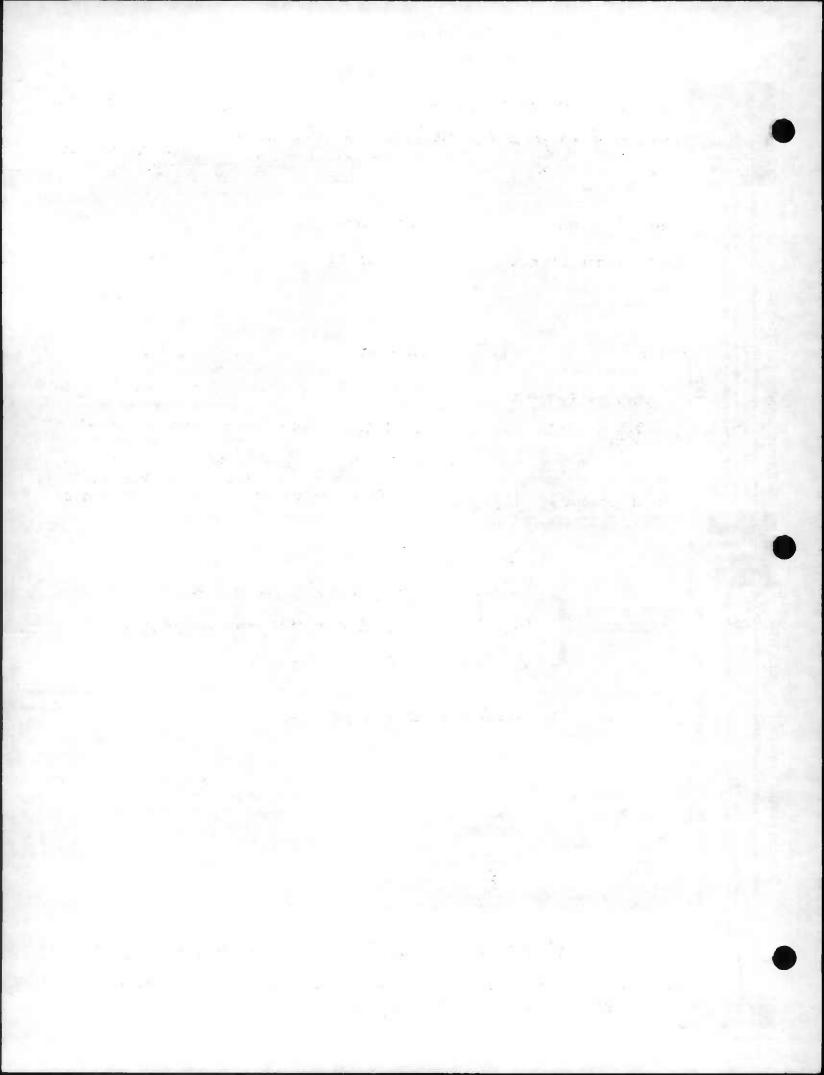
32 Registrial Significian Randall

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

Blackmon

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene Q

			00			Death			Reg. No.			
1. Decedent's Neme (First, Middle, Li	ast)						2	Dete of De	eth			3. Time of De
CHARLES RUDOLPH (GEILFUSS							Month APRIL	Dey 21		aer 98	04:26 A
4e. Fecility Name (If not institution, gi	va street and numb	er)		-	- 4	4b. City, Town				County of I		104.20 1
GREATER BALTIM	ORE MEDIC	CAL CE	NTER			TOUSO	N		B/	ALTIMO	ORE	
5. Sociel Security Number 6.	Sex 7. 1 M 2 □ F	Age (In yrs.	last birthday,	If Und	er 1 Yeer s Devs	TOWSO If Under 24 Hours	Hrs. 8	Defe of Bir (Month, De				elece (Stete or Fo
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Usuel Residence of Decedent 10e. Steta 10b, County		100 0	ty, Town or L									
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9 Ruxview Ct.					L204					ed St	cate	es
11. Meritel Stefus	12. Was Decede Armed Force 1 Tyes 2	enf Ever in U es?	I,S. 13.	Was Dac If Yes, sp	edent of H ecify Cube	lispenic Origir en, Mexican, F	? (Speci Puerto Ri	fy Yas or No can, etc.))-	14. Race - A Bleck, V		
1 Navar Marriad 2 Married	If Yes, Give			1□ Yes	2 X No	Specify:				Specify:	Wha	ite
3 ☐ Widowed 4 ☐ Divorced	Yeer or Dete	9S:				and the second						
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Mary Evelyn Geil:		r	1-	view		end Number of			er, City oi L204	r Iown, Sta	ite, Zip	Code)
20e. Method of Disposition	rassi wire		Plece of Dispo			TOWS		Dete		cation - Cit	T.	Otata
1 N Burial 2 ☐ Cremafion 3 D		ate	cemetery, cre	metory or	other plea	-						Later
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21. Signeture of Funerel Service Lice	nsee MITY		2	2. Name e	end Addre	ss of Fecility	Mitc	hell-V	Viede	efeld	Hor	ne, Inc.
Somo ma	Hell							York		2121	2	
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Registra DHMH 16 Rev 6/95

Phys /Me Exan

Funera Directo

permit. Peges 1 and 2 should be filled within 72 hours after death with the Meryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumatic event, its Medical Examiner main the notified at

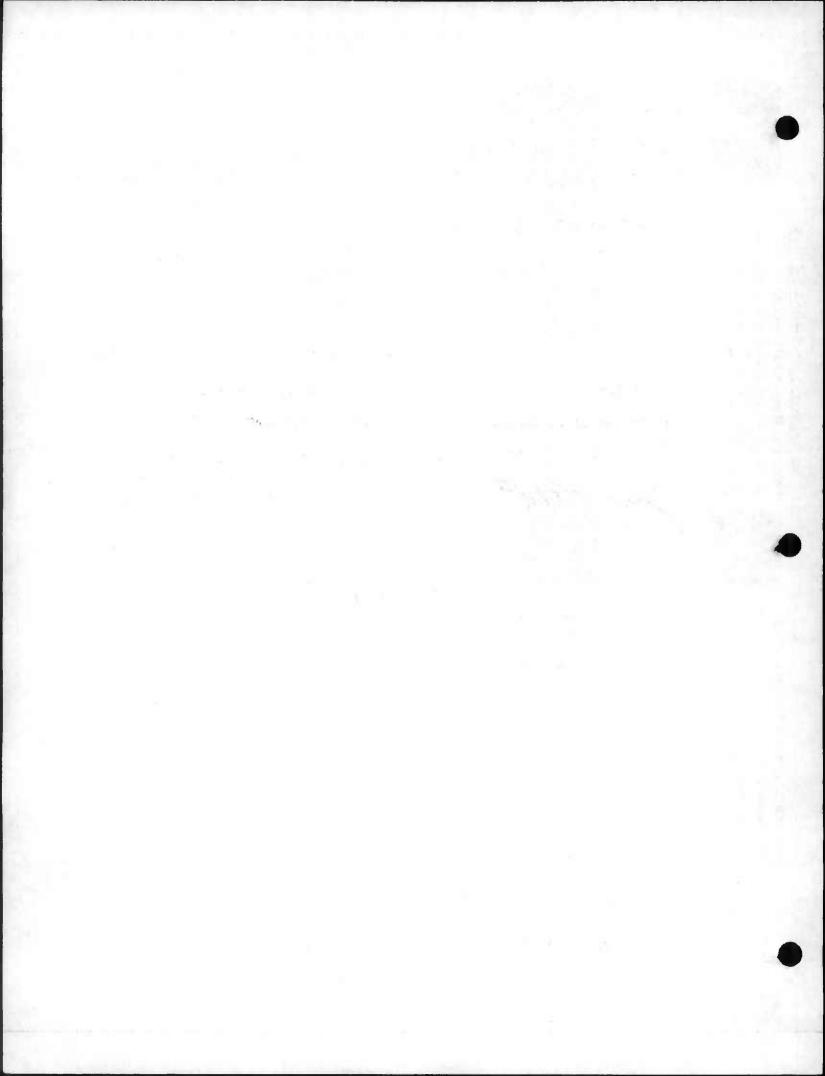
Physician /Medica Examine

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

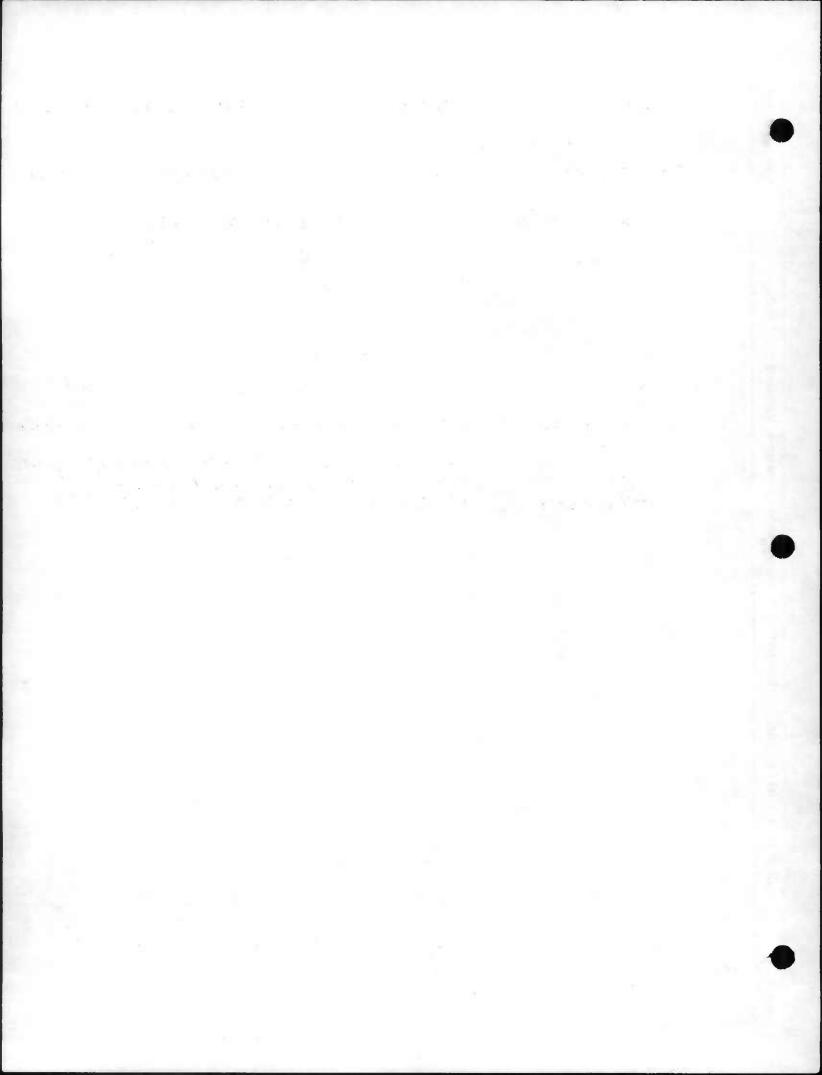
Division of Vital Records, P.O. Box 68760.

Sell Fuss,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of IV	iai yiai	Certifica				Reg. No.		291	3
	Discontata-		1. Decedent's Name (First, Middle, L	est)					2. Date of De Month	ath Day	Year	3. Time o	f Death
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	Examine		4a Facility Name (If not Institution, gi	ve street and number)			4b. City, Town, or L		4c. County	of Deeth		
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L	Funeral Director			Sex 7. A	ge (In yrs.	Month Vrs.	er 1 Year s Days	Hours Min.	(Month, De	th y, Year) 31, 1914	9. Birthp Sour	-11/1-	or Foreign ROLINA
	hend wo	-	10a. State 10b. County		10c. Cit	ty, Town or Location					1	Od. Inside C	ity Limits
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U		edent of I	Hispanic Origin? (Spar, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Rac	e - Americ k, White,	ean Indian, etc.	
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	Physician		shock, or heart failure. List only	ona ceuse on each	ine.						1	Interval Be Onset end	Deeth
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Division	or Attending Father deeth. Director: After I in by the funer	Certification:	3 Suicide 6 Could not	28e. Place of Ir	jury - At h	ome, farm, street, fact	ory, office			Street and Numb	er or Rur	al Route Nur	n <i>ber</i> ,
Div	after Dire	2	4 Homicide	building, e	tc."(Speci	<i>fy)</i>			City or To	wn, Stete)			
		edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best minar: On the basis and manner s	of examina	owledge, daath occurrention and/or investigati	ed at tha ti	me, date and plece opinion, deeth occu	, and dua to tha rred at the time,	cause(s) and ma data and place,	innar as s end due t	stated. o the cause(s)
	o the	_	29b. Signature and title of certifiar	WING III GIVINGI 3		1 2	9c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
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•	m	-	30. Name end address of person who	,		23a) (Type Print)							
	7		Rm 206	82	1	~ Cu	tan	street	Ba	et md	21	20/	
	State Registra	-	31. Data filed (Month, Day, Year)	32. Regis	rar's Sign	andell						•	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Carrie 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 1998 0920 CARRIE W. HARRISON April * /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 6 Sax Birthplaca (Stata or Foreign Country) **Funeral** Days 1 □ M 2 T F Months 8.5 07 - 21 - 12Director New Jersey 217-36-2139 Usual Rasidance of Decedan death with the Maryland 10a Steta 10h Counts 10c. City. Town or Location 10d. Insida City Limits worle 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examination must be incitited at 1 Yas 2X No Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21875 9415 Ocean Hwy US Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14 Race - American Indian 11. Maritai Status Black, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours efter of Department of Health end Mental Hygiene. Important: if Item 27 is merked other than "natural", or item any injury or other traumatic event. the 1 □ Navar Marriad 2 □ Married if Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: PV 3€XWidowed 4 Divorced white Completed 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation 15. Decedent's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Richard Wells Bessie Wells 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Naylor R. Harrison Jr. - son 3009 Old Rt 50, Cambridge, MD 21613 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 Donation 5 Othar (Specify) Wicomico Memorial Park 4/22/98 Salisbury, MD 21. Signature of Funar Jurvice Lican 22. Nama and Addrass of Facility Crumtor Cranston Funeral Home Cranston P O Box 967, Seaford, DE 19973 ohn A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death Physician /Medical Immadiata Ceuse (Final disaasa or condition rasulting in daath) 5 years Examiner Examiner buriel-tran Sequantially list conditions, if any, leading to Immadiate causa. Enter Undarlying Cause (Disaasa or injury that Initiated avants rasulting in daath) Last Due to (or es a consequence of): pue physician Physician/Medical the Dua to (or as a consequanca of): 80 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying couse given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown signed by þ 24b. Wara autopsy findings available prior to mellitus 24e. Wes en eutopsy Completed compiation of causa of death? certificate has 2 No Chronic obstructure 1 ☐ Yes 2 ☐ No pulmonory 1 Yas funeral director, 25. Wes cesa rafarred to medical axaminar? Be 26. Plece of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Yas 2 No 10 1 Inpatiant 2 ER/Outpatiant 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Netural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant ofter deatl 3 Suicida 6 Could not ba 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide ò 24 hours e Hospital Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner as stated.

[2] Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the F within 2 29d. Date/signed/(Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifie 98 D30853

PRMC

State Registrar

30. Name end eddress of person who completed cause of death (ttam 23e) (Typa, Print)

R 2, 4 1998

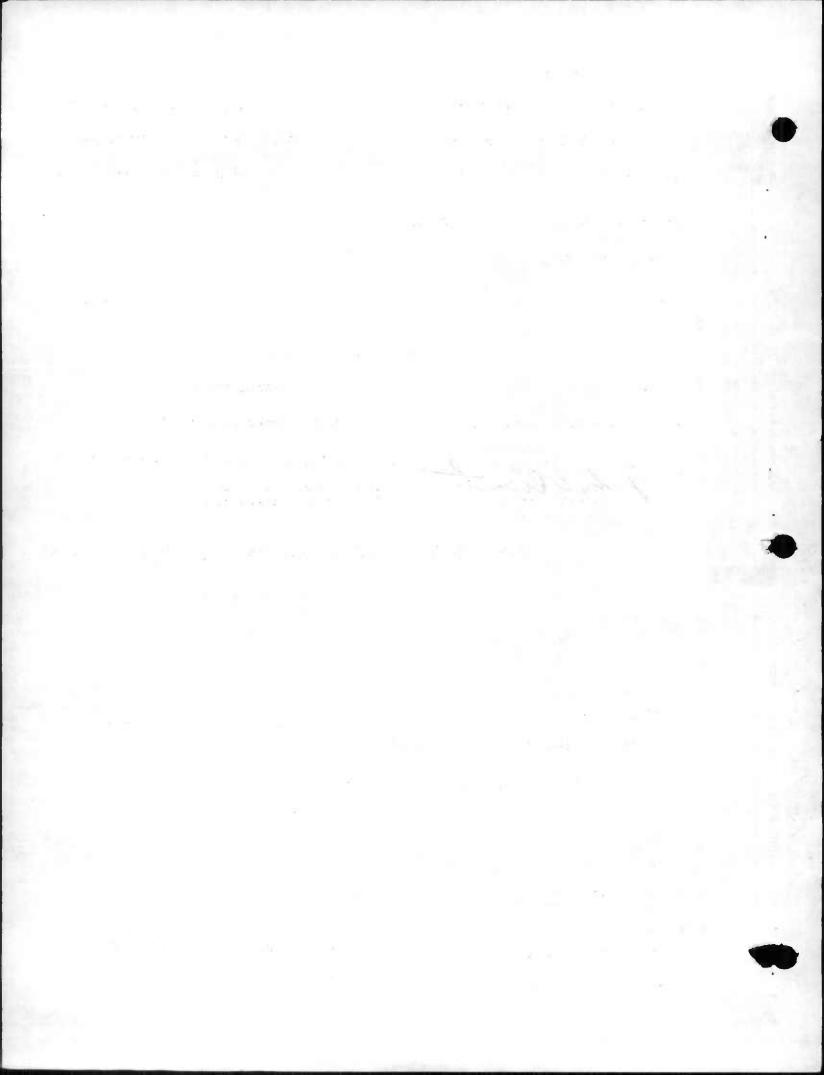
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month TENRO 1998 April 21 UTH 4b, City, Town, or Location of Daath 4a. Facility Nama (If not institution, give street and number, 4c. County of Deeth Baltimore AGNES HOSPITAL If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) Days 1 M 2 F Yrs 219-22-0472 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore NYas 2 No am 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21229 DSA 400 a Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 12. Wes Dacedant Evar In U.S. Armed Forces? 14. Race - American Indian, Bleck, Whita, etc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married Blac 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist Hospita 7+h 17. Fether's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Meidan Sumama) SIDNEY NOZUNOL RANCES KEIT 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Address (Street end Number or Rural Route, Number, City or Town, Stata, Zip Coda) Ras lyn Ave 140. Marvin McFadden-Nep md. 2406 20b. Place of Disposition (Nema of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4-25-98 Daltinose Md Cemptery 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Servica Licensas Home West Da Ho 4300 Wabash 21215 Ave-23a. Part I Enter the Usaasa, or complications that ceusad the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart heilure. List only one cause on each line. Approximete Interval Batween Onset and Death Immediata Cause (Final a Adenocarcinona disaasa or condition rasulting in death) Unknown Due to (or as a consequence of) Metastasis Unknown Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Ceusa (Disaesa or Injury that Initiated events rasulting in deeth) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 38 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No 25. Was cesa rafarrad to medical axeminer? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Minpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

NAME HEARY, Ruth To the Hospital or Attar within 24 hours efter der To the Funeral Director completely filled in by th

> State Registrar

Physician

/Medical

Examiner

Director

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Completed

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Physician/Medicai

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Completed

Certification:

Medical

29a. Cartifiar

Funeral

Director

tam 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Department of Heelth and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a any injury or other traumatic event. The Marcal Examine name

Physician /Medical

Examiner

the

been signed by the attending should be detached for use as

funeral director,

After

Director:

Baltimore, Maryland 21215-0020

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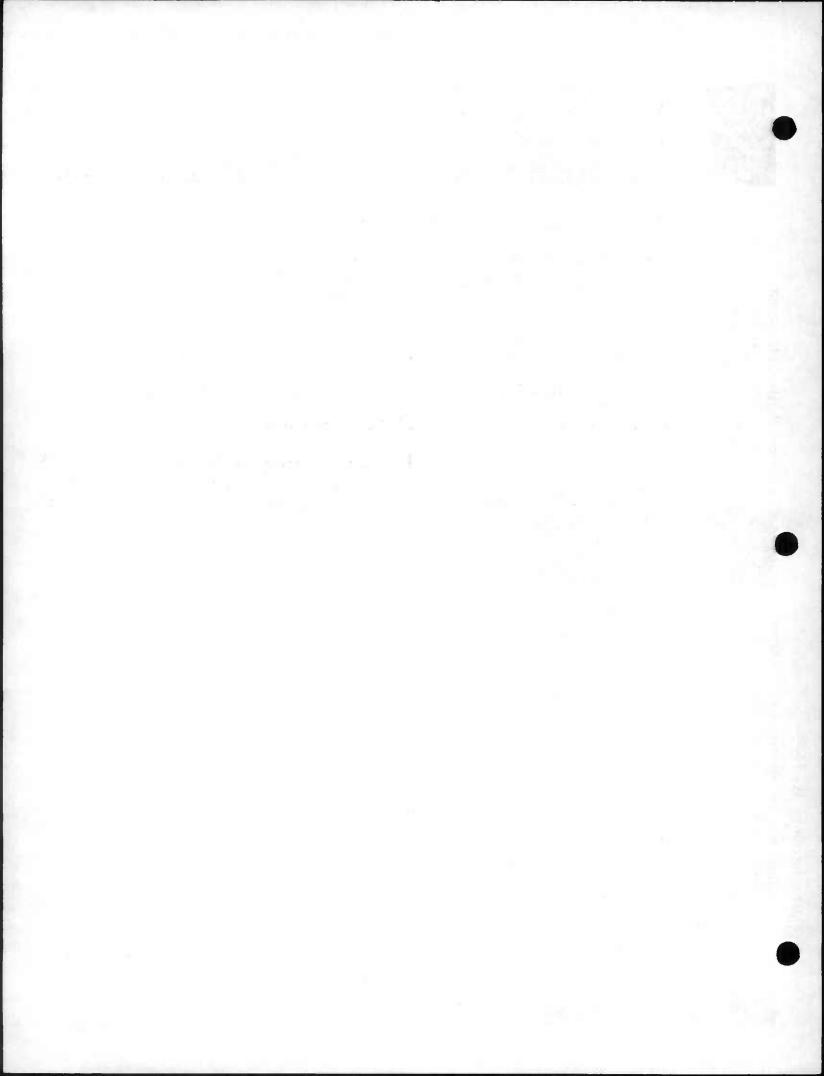
1 (Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, date and place, and due to tha ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signatura end titla of certifier 29c. Licansa number 29d. Data signed (Month, Dev. Year)

30. Nama and eddrass of parson who completed ceuse of death (Item 23a) (Type, Print)

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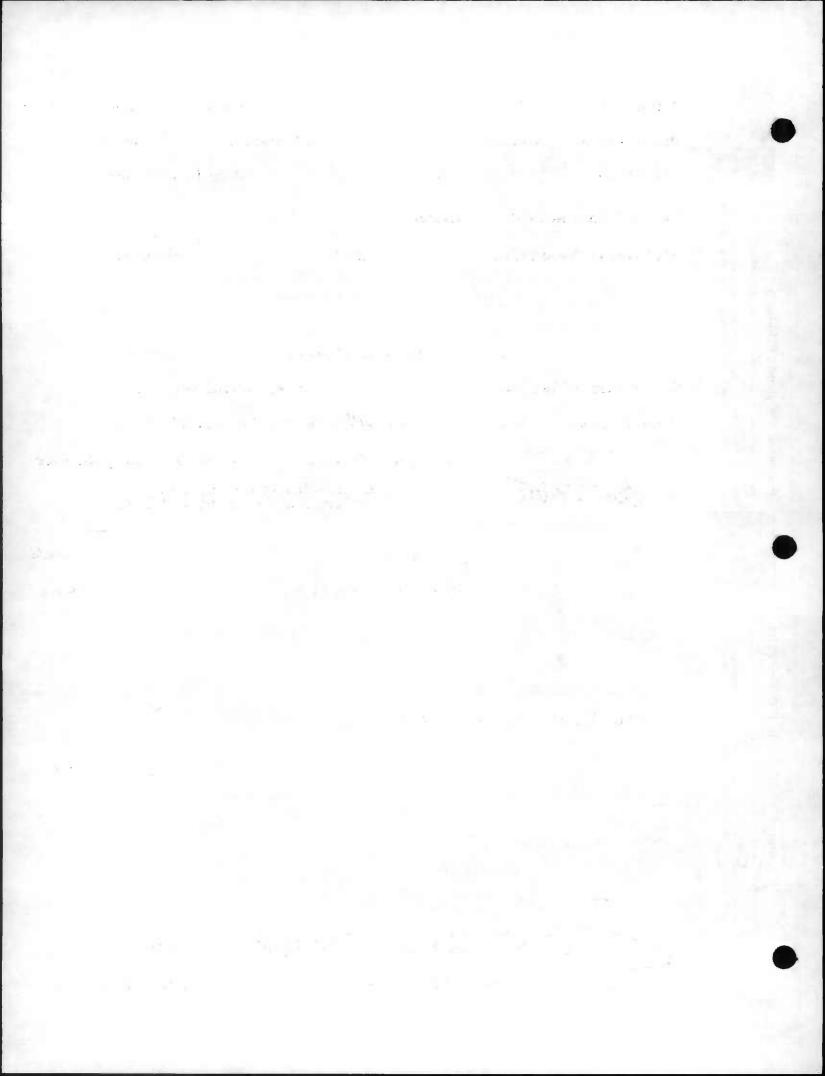
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Date of Death **Physician** Alice Harwood Houstle 4:30 AM April 1998 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Brightwood Nursing Center Lutherville Baltimore If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Steta or Foraign
Country) **Funeral** Months Deys Hours Min 1 M 2 F 85 Yrs. 218-09-2283 Maryland Director June 13 1912 Usual Residence of Decedent the Marylend permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health end Mental Hygiene.
Important: If itsm 27 is merked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evantine invest by northed an once. 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Laurel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Forest Haven Drive 20724 United States Funeral 14. Race - Amarican Indien, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: À 3 X Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Artistic Director 5+ Theater 18. Mother's Neme (First, Middla, Meiden Sumema) 17. Fether's Name (First, Middle, Last) George Joseph Clautice Janet Harwood Wellmore 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3517 Forest Haven Drive Laurel, MD Peter M. Houstle / Son 20b. Plece of Disposition (Name of cametery, crematory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal trom State 4 □ Donation 5 □ Othar (Spacify) 4-25-98 Baltimore, Maryland Greenmount Crematory 22. Nama and Addrass of Facility
Mitchell-Wiedefeld Home, Inc. 21. Signature of Funerel Service Licensee dever 1. 6500 York Road Baltimore, MD 21212 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death Physician about 1 /Medical Immediate Causa (Finel week disaese or condition resulting in deeth) Examiner Examiner physician end the burial-transit the daath certificeta be axecuted Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseesa or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): 98 esn Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Dementa þ 2 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 2) = No certificate 25. Wes case reterred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 → Pursing Homa 5 □ Residenca 6 □ Other (Specify) 10 1 Yes 2KINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: ivision 1 Daturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 施豐 24 hou Funer 29a. Certifier edical Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as steted. 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) To the F within 2 29b. Signature and side of certifi-29d. Date signed (Month, Day, Year) Medical. Altendina April 22, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Old Court Road Suite 203 Baltimore, MD Paul Schwartz, M.D. 32. Registare Signature
June Davidson-Rands 12 State Registra

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22,1998 Samue 4a. Facility Nama (If not Institution, give street and numbar) 4b. City. Town, or Location of Death John Hopkins Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days 1₽M 2□ F 70 **Vrs** 248-384428 Jun. 22, 1927 South Carolina Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Millersville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Chalet Drive 21108 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 BrYes 2 □ No If Yes, Give Year or Dates: 1945–68 1 Never Marriad 2 Married 1□ Yes 2□ No Specify 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. Army 12 Master Sgt. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Cleveland Hardy Maggie Littlejohn 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Deanie M. Hardy - Wife 318 Chalet Drive, Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cramation 3 ☐ Removal from State Arlington National Cem. 4/29 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting In death) Last our Disease 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performad? 1 ☐ Yes 2 XNO 1 ☐ Yes 2 No

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permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s any Injury or other traumatic event, an Medical Exaction man.

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Physician/Medical Examiner þ Completed Be

Certification: To n 24 hours after dea ne Funeral Director nately filled in by th Medical

To the Hosp within 24 hor To the Fune completely fi

State Registrar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 II Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation in a resistant to the causa (s). 29a. Certifier Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and manner stated. (Check only one)

29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year)

completed cause of deeth (Item 23e) (Type, Print) Ir, MI Johns Hopkins Hospital GOIN Wolfest

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** April 21, 1998 4:20 PM Joan Marie Huncher /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner 2004 Searles Road Dundalk Baltimore 8. Dete of Birth (Month, Dey, Year) May 23,1933 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 ☐ M 2 🕃 F 64 Yrs. **Director** 218-28-4672 D.C. Usuat Residence of Decedent pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinat must be notified at PAGE. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2004 Searles Road 21222 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried XX Married 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Department Store G.E.D. Head Cashier 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Jacob Robert Schroll Genevieve Marie Smith 19e. Informent's Neme/Reletionship (Type, Pnint) Husband | 19b. Meilling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2004 Searles Road Dundalk, Maryland 21222 Mr. John J. Huncher, Sr. 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State Sacred Ht. of Jesus Cem, 4/25/98 Dundalk, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funerel Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the shock, or heart feature, or templications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and they one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Final disease or condition resulting in deeth) a NON-SMILL CELL LUNG CINCER 2 YEARS Examiner Due to (or es e consequence of). Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 80 080 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 No 3 Probably 4 Unknown OBSTRUCTUE LUNG OUSEASE p 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? been si 24e. Wes en eutopsy Completed certificate hes b lirector, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 No director 25. Wes case referred to medicel exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpetient 3 DOA this funerel 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? Certification: After 1 Neturet 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter deat Director: 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. 3 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number

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32. Registrar's Signature

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

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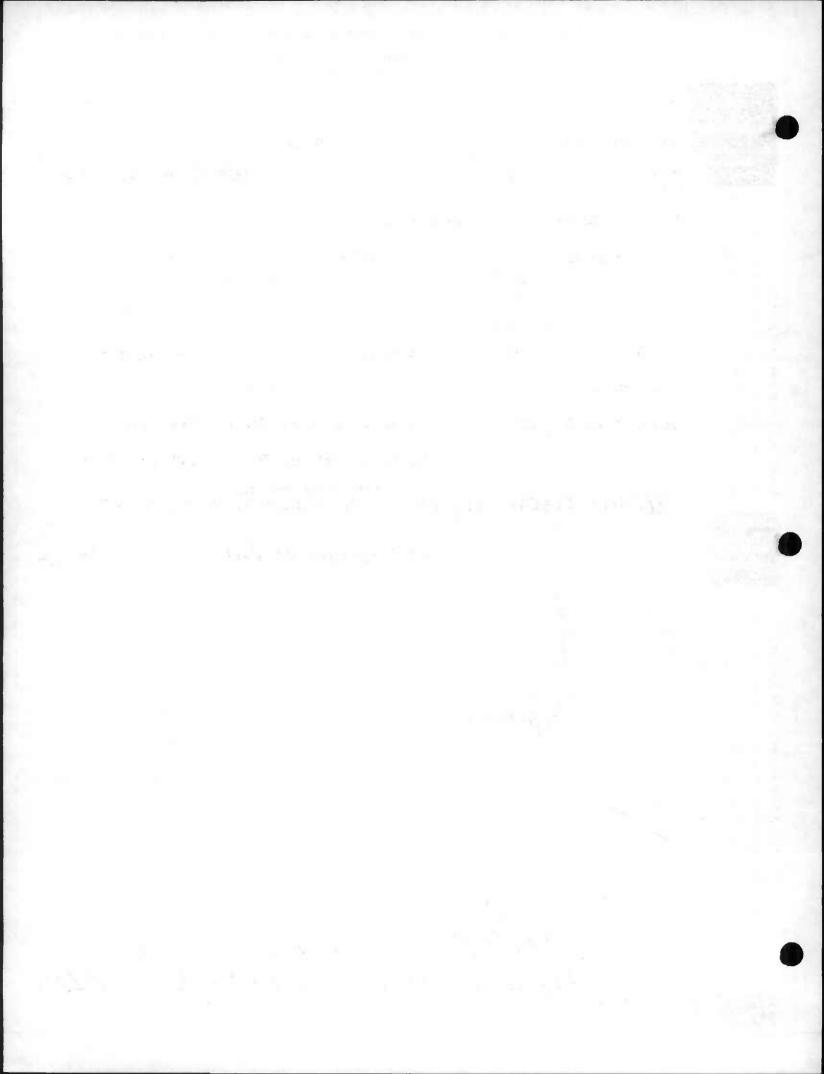
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** April 21, Alice Mary Hanlon 6:45 pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Manor Care- Ruxton Ruxton Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Yrs. 214-44-9043 87 Director Dublin, Ireland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21236 9207 Greenhouse Circle USA Pages 1 and 2 should be filed within 72 hours aftar death nent of Health and Mental Hygiena. Int: If Itam 27 Is marked other than "natural", or Itams 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritel Status Black. White, etc. 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White by 3 ☑ Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Cook/Server Mercy Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Carroll Mary Dillon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if Itam 27 is any Injury or other trau 9207 Greenhouse Circle Margaret Duvall (Daughter) Baltimore, Maryland 21236 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete tX Burial 2 ☐ Cremation 3 ☐ Removel from State Parkwood Cemetery April 23, 1998 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility Lassahn Funeral Home, Inc. Drock 7401 Belair Road Baltimore, Maryland 21236-4625 23a. Part 1. Enter the disease, or complications that caused be leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician cerebrourscular Azcident /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): physician the burial Box 68760. Due to (or as a consequence of) 950 Po ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 No 3 Probably 4 Unknown ty Nertension Completed by should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: A the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F 29b. Signeture end title of certifler 29c. License number 14E. Joppa Rd #103, BALTAMOR, MD 21234 30. Name and address of persoftwho completed cause of death (Item 23a) (Type, Print) roky when 7890A 31. Date filed (Month, Day, Year) State APR 24 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Dete of Death 3. Time of Deeth Hutchins Month 04 0155 A.M. Tussell Morgan 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Bayview Tohns Hopkins Baltimore Ba/Imore 5. Sociel Security Number 6. Sex If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country)

A 187-05-5246 MEM 2□ F Months Deys (Month, Day, Yeer) 03, 18, 1913 85 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XIXNo Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8101 Bletzer Road 21222 USA 12. Wes Dacedent Ever in U,S. Armed Forces?

1 Yas 2 No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - Amaricen Indian, Black, White, etc. 11 Maritai Stetus 1 Never Married 21 Married 1 ☐ Yas 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) MAchine Operator Beth Steel 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surneme) Soloman Hutchins Anna Hartman 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marie Hutchins/wife Bletzer Road Baltimore Md. 21222 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) OakLawnCemetery 4/25/98 Baltimore Md. 21. Signature of Funaral Service Licensea 22. Name end Address of Facility Connelly Funeral Home of Essex 23e. Part1. Enter the disease, or complications that caused the death. Do hot mater tha mode of dying, such as cerdiac or raspiratory errest, Approximete shock, or heart feilure. List only one cause on each lina. Intervel Between Onset end Death Immediate Ceuse (Finel cerebrovascular accidents disaasa or condition resulting in deeth) hronic atrial fibrillation months Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): disease Coronary Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Congestive heart failure 3 Probably 4 Unknown 1 Yes 2 No 24b. Wera eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Dev Year) 28b. Time of 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

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29b. Signetura and titla of certifier

29a. Certifier

Physician/Medical Examiner Sign be certificate Certification:

Physician

/Medical

Examiner

Funeral

Director

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21215-0020

Baltimore, Maryland

Box 68760,

P.O.

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permit. Pages 1 end 2 sh Department of Health end Important: if item 27 is m eny injury or other traum

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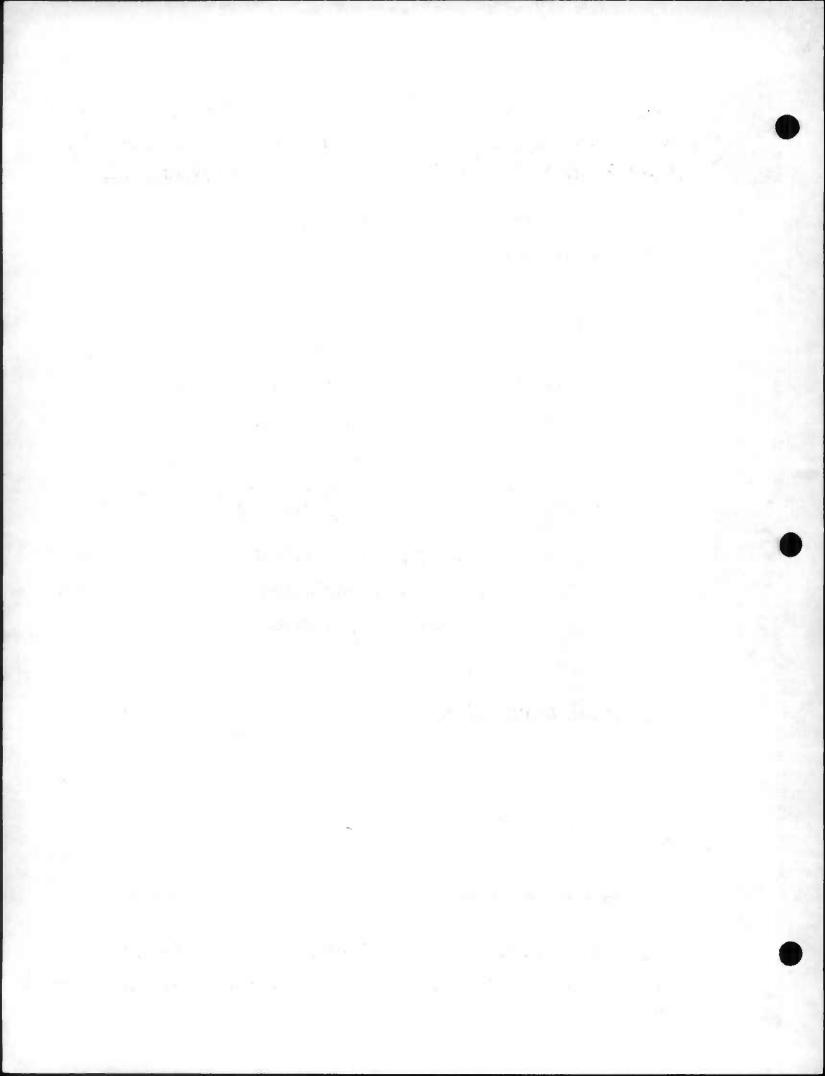
29c. License number

12xCertifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha time, data and place, end due to the cause(s) end mannar statad. 29d. Data signad (Month, Dey, Year)

d cause of deeth (Item 23e) (Type, Print)

David Geschward MD, PhD, Dept. Newslogy, John Hopkins Bayujew Hospital, Baltimore, MD 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nerpe (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Saco **Physician** 14:49 /Medical 4b. City, Town; or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimor nary hivers: 01 if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex (in vrs. last birthday) 8. Birthplece (State or Foreign **Funeral** Months Deys Min. 38 Hours 10 M 2□ F 3 Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f shov the Medical Examinar must be notified at 1 Yes 2 No Directo lan4 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21 Funeral O Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Raca -American Indien, 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Yeer or Detes Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) nd Mantal Hygiene. 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be permit. Pages 1 end 2 should be I Department of Health end Mantal I Important: If Nem 27 is marked or any injury or other traumatic eve ean (Brother 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Neme/Reletionship (Type, Print) Stete, Zip Code) 19e. Informent's 14.2122 S 415 Linu 20b. Plece of Disposition (Name of 200 to 20e. Method of Disposition Dete 20c. Location - City or Town, Stete or other place cremetory 1 Buriei 2 Cremation 3 Removal from State 4 Donetion 5 Dother (Specify) 22. Name and Address of Facility 21. Signatu any ir Ave North 2.2.22 ed the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, line. Approximete Intervel Betw Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of). Physician/Medical Examiner attending physician and for use as the burnt-transit The law requires that the death certificant by executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events Due to (or es e consequence of) thet initieted events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? has t paga 2 X No 1 ☐ Yes 2□ No certificeta 25. Wes case referred to medicel exeminer? To Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 2 FR/Outpetient 3 DOA 1 Inpatient 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 2 No 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funaral director, I edicai

Baltimore, Maryland 21215-0020

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examination the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier

29e. Certifier

(Check only one)

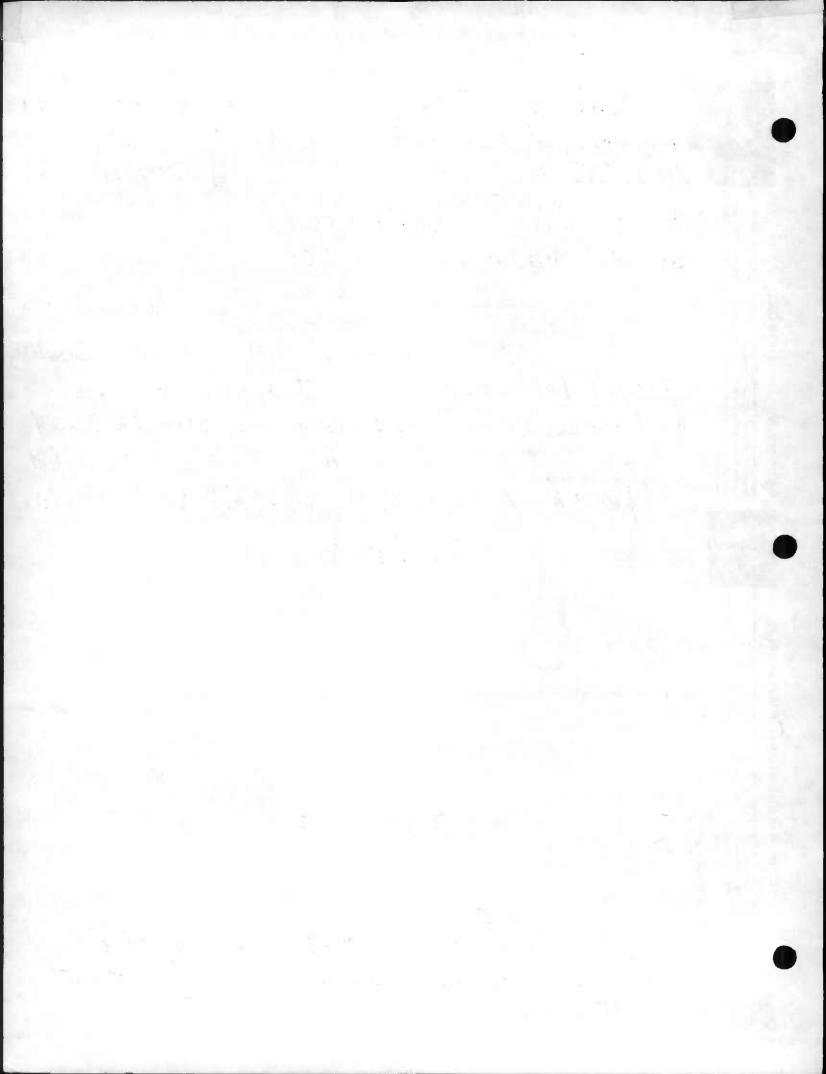
29ç. License number 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

1998

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a Signature 32. Regis in Davidson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 4b. City, Town, or Location of Deeth :3 NORMAN R. JAMISON /Medical 4c. County of Death 4e Fecility Neme (If not institution, give street and number) OSECIALE IN Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) May 16, 1929 Examiner Baltimore -an Klin Square Hospital Center 6. Sext 7. Age (In yrs. last birthdey) If Under 1 Yea If Under 1 Year Birthpleca (Stete or Foreign Country) A 5. Sociel Security Number **Funeral** Days 180 M 2□ F 69 Yrs 214-26-2006 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Md. Baltimore Middle river Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Middle River Road 21220 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritai Status Bleck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry le marked other than Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. self-employed 9th body-fender shop 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Mentel Warren Lee JAmison Ferne E. Loar of Heelth and N 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) PAtsy Pitt / neice 514 Middle River Road Baltimore Md. 21220 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Slele 20e. Method of Disposition Dete Department of I Important: If Ita any Injury or of ♦ Communication 3 Removel from State BelAir Memorial 4/27/98 BelAir Md. 4 Donetlon 5 Other (Specify) 21. Signature of Funerel Servica Licensee 22. Name end Address of Facility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** immediate Ceuse (Final disease or condition resulting in deeth) /Medical 6 hours Imonary **Examiner** Due to (or es e consequence of): Physician/Medical Examiner ongestive Cardiac railure physician and the burial-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest schemic Cardio myopat Due to (or as a consequence of): Artery DISEAS oronary 23b. Did tobecco use contribute to the cause of deeth? by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. chronic Obstructive Pulmonary 3 Probably 4 Unknown 1 □ Yee 2 No þ 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? hes e 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner steled. 29a. Certifier

Division of Vital Records, P.O. Box 68760, The law requires that the Physician: Hospital < 24 hours a Funerel D within 2

death certificate be executed

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altimore,

edical (Check only one)

29b. Signature and ti

29c. License number 42083

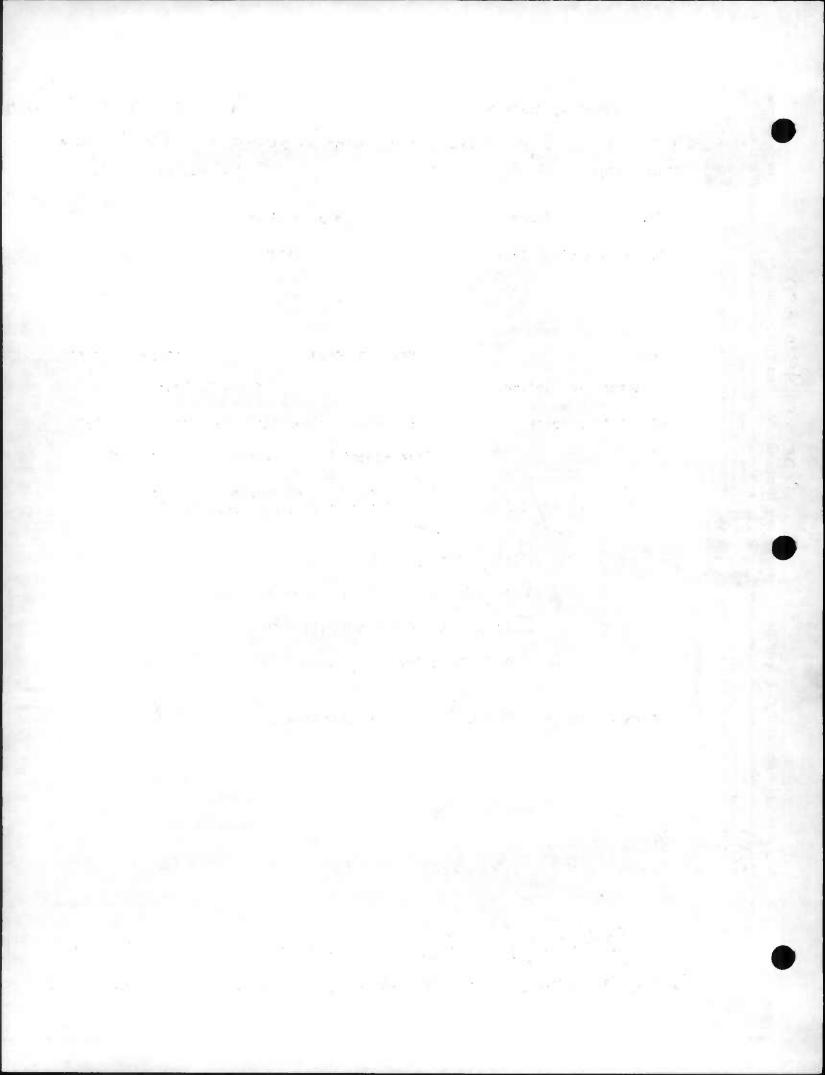
29d. Date signed (Month, Dey, Year) April 23, 1998

30. Neme end ad ress of person who completed cause of deeth (Item 23e) (Type, Print)

er 9000 Franklin Square Drive Baltimore, MD 21237 Dr gunta Wheet 31. Defe filed (Month, Dey, Year) 32. Registrar's Signeture

State Registra

Davidson Andell 2.4



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 22, 1998 April 12:34 Minnie Mae Kelso 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Millersville Arundel Knollwood Manor Genesis Eldercare Anne 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1□M 2□F JUNE 21, 1902Tennessee 410-16-9127 Usual Residence of Deceden 10c City Town or Location 10a State 10h County 10d. Inside City Limits Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 North Crain Highway, Apt. 945 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ▼□ No Specify: Specify: White 3.☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Alexander Kelso Mary Elizabeth Carver 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth N. Sparks/daughter Severn, MD 21144 1415 Norcross Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 □ Burlai 2 ☐ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/23/98 | Baltimore, MD 22. Name and Address of Facility 21. Signature of Juneral Service Lie Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 212 Edward A. Grego 21228 23a. Part1. Enter the disease, or complicator's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only consider the death. Approximate Interval Between Onset and Death Heart age Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Irean Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 21 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one)

Physician /Medical Examiner

Examine

Physician/Medical

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Be

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Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

Director

Funeral

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rall, or items 23s or 28s-f shov Examiner must be notified at

"natural", or

other

permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: if item 27 is marked oth any linjury or other traumatic event page.

filed within 7 Hygiene.

other traumatic event, the Medical

Maryland

death

팊 signed by t Completed peen s page 2 s

After this funerel death. the 24 hours efter deat Funeral Director: filled in by

5 To the Hosp within 24 ho To the Fune completely fi

MINNIE MAR KELS

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

4 Homicide

29a. Certifier

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be determined

31. Date filed (Month, Day Year) APR 2 4 1998

1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 28e. Date of Injury (Month, Dey Year)

28b. Time of

32. Registrar Spratue

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

216

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day. Year)

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

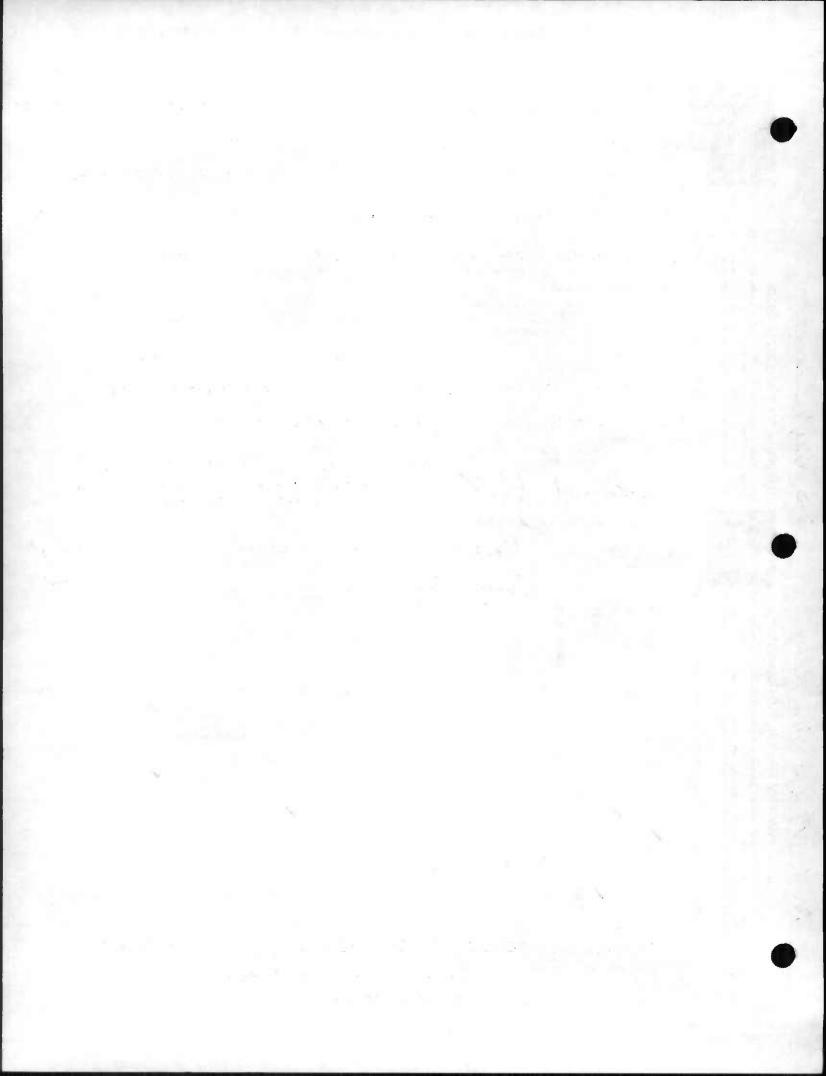
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

Attenday Doctor

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 8109 RITCHIE the 4 N. CYRIAC. M.D

PASADENA, MD21122

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#5,7 per FH G758 4/24/98 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LATHAM Month 3.30 am IESSE PRIL 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street end number) 4c. County of Death GOOD SAMARTIN HOSPITAL BALTO N/A 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 15, 5. Sociel Security Number Birthplace (State or Foreign Country) KT 1 □ M 2 □ F 1937 402-46-5826 Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits YSYes 2 No N/A BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1019 EVESHAM AVE 21212 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 X Yes 2 □ No 1962 If Yes, Give Year or Dates: 1965 1 Never Married 2 Married

1 ☐ Yes 2√ENO

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

CORRECTIONAL OFFICER

Specify BLACK

CITY OF BALTO JAIL

Approximate Interval Between Onset and Deeth

doy

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

MEMIE SCOTT

Lock Raven Blud, Baltimore 21239

tem 27 is marked other then "natural", or items 23s or 25s-f sho other treumstic event, the Medical Examinat must be notified at permit. Pagas 1 and 2 should be filed within 72 hours after Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other then "naturelt, or item any injury or other treumetic event, the Mad call Exempted. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a State

MD

3 Widowed 4 X Kivorced

Elementery/Secondery (0-12)

FRED

17. Father's Name (First, Middle, Last)

15. Decadent's Education (Specify only highest grade completed)

LATHAM

N A College (1-4or 5+)

Funeral

Director

28a-f show

"natural", or items

Director

Funeral

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Completed

Be

the Maryland

Physician /Medical Examiner

and

Box 68760.

Division of Vital Records, P.O.

Examiner Physician/Medicai by Completed Be Certification: To

attending physician peen has paga 2 cartificata To the Hospital or Attending Physicien: within 24 hours aftar dash.
To the Funeral Director: Aftar this cartifica completely filled in by the funaral director, it

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EARTHINA LATHAM 019 EVESHAM AVE BALTO, MD 21212 APRIL 2820c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) GARRISON FOREST VA CEM 1998 OWINGS MILLS, MD 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signature of Funeral Service Licenses 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) $hs\omega$ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) neumonia Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown senal disease 24a. Was an autopsy performed? 1 Yes 2 (NO 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Dempatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide 29a. Certifie 1 crifying Phyaiclan: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

pleted cause of death (Item 23e) (Type, Print)

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32. Regist

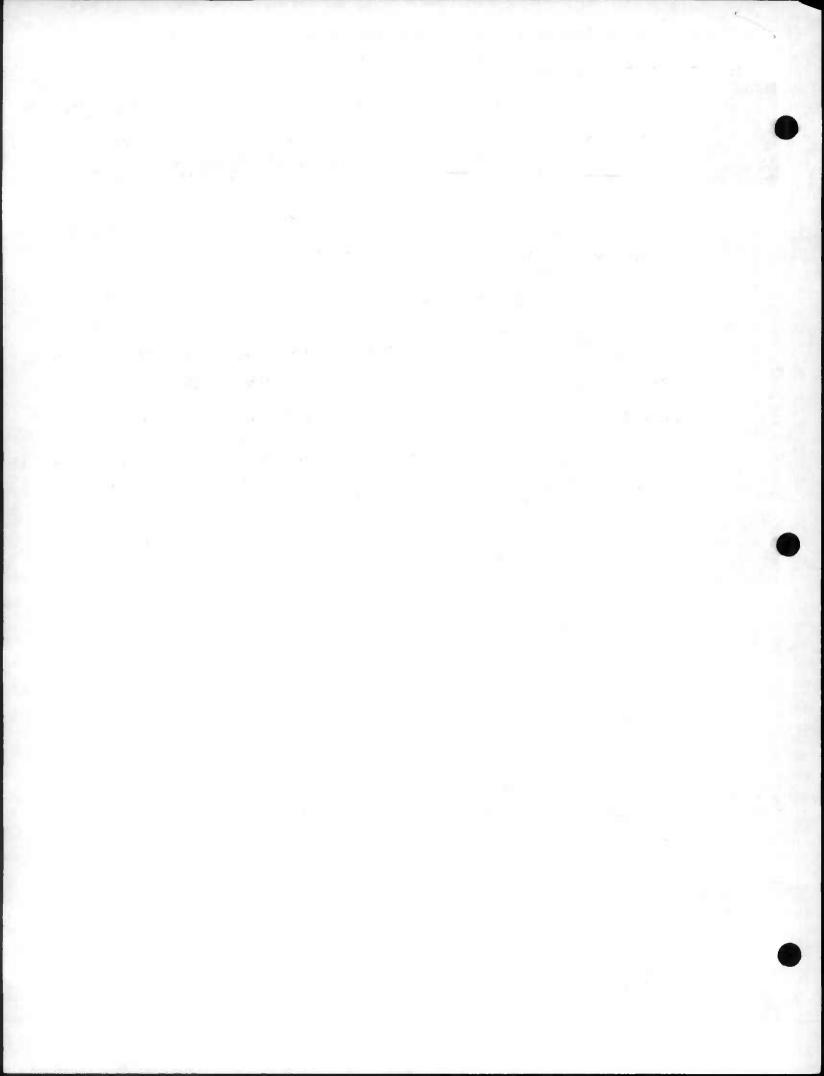
State Registrar

Medical

30. Name and adds

31. Date filed (Month, Day, Year)

APR 24



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GEORGE ANTHONY 2:35PM April 22, 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonuim Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral X**X M 2□ F Months Yrs. 217-05-4489 Director November 11,1915 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 2300 Dulaney Valley Road 21093 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces?

1 Yes XXNo
If Yes, Give items Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 🕅 No Specify: White þ XX Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Petroleum 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health end Mental Hy
important: if item 27 is marked oth
any injury or other traumatic event 18. Mother's Name (First, Middle, Malden Sumeme Be George Anthony Lurz Loretta Mildred Keating 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M Guidera 6101 Bellona Avenue Baltimore, Maryland 21212 Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
XXXX surial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4/24/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Signature of Funeral S. 22. Name and Address of Facility Mitchell-Wiedefeld Home Inc nnus 6500 York Road Baltimore, Maryland 21212 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CANCER OF LUNG disease or condition resulting In death) Examiner Examiner Attending Physician: The law requires that the death certificate be executed ician end buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) physician s the buriel Box 68760. Physician/Medicai Due to (or as a consequence of): 98 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ sign be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No on of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

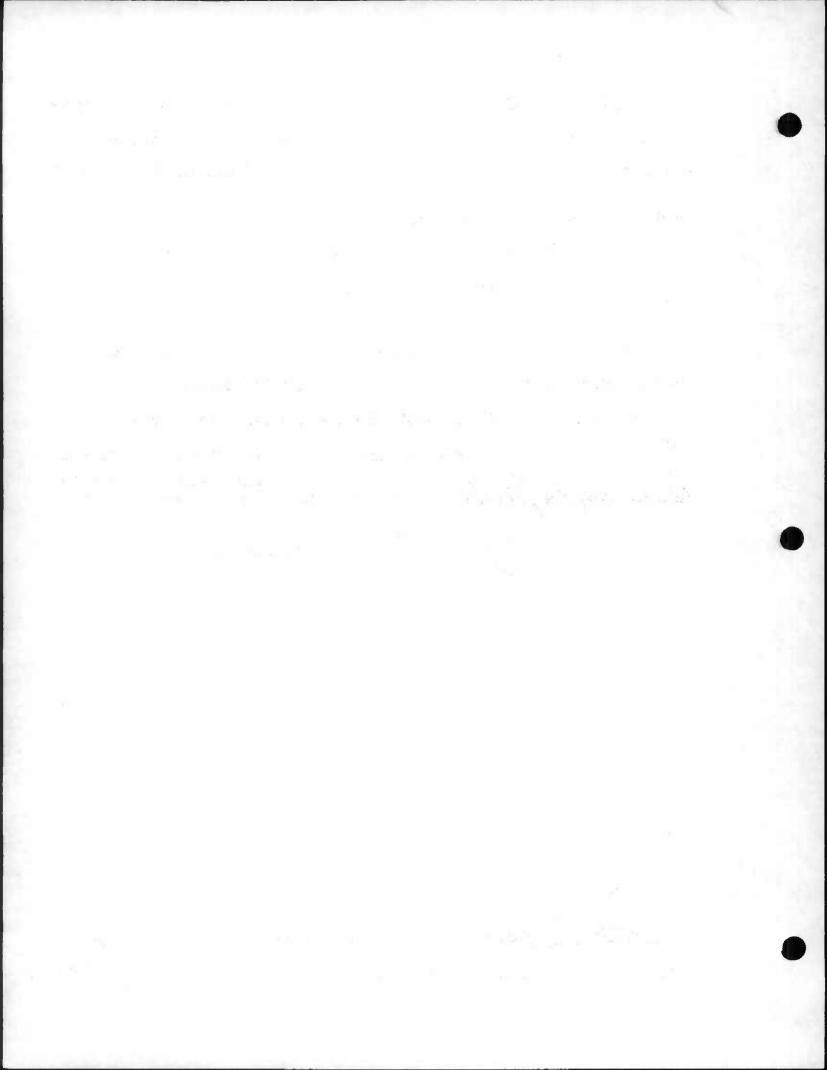
Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Division 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Hospital br/Att 24 hours after of Funeral Direct 4 Homicide To the Hospital within 24 hours a To the Funeral Completely Med edicai 29a, Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es steted. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25686 7-23-98 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) OSCER DRIVE BATTHERY EBRAHIM IPAK CHI MO 7600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

2 4 1998

Julia Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Albert Stephen Lane 22, 1998 5:40 pm Apr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1921 Stone Castle Drive Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□ F Months Days Hours 18 Yrs. Director 219-25-0102 Mar.6,1980 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Meryland Department of Heelth and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, or a Medical Expressional Front and Dece. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Severn 1 ☐ Yes 2 No Director 10e. Street and Number 1921 Stone Castle Drive 10f. Zip Code 10g. Citizen of Whet Country? 21177 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 15 Never Married 2□ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Student Education 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Richard Lee Lane Jr. Olga Juarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Lee Lane Jr. Father 1921 Stone Castle Drive, , Severn, MD 21177 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2X Cremetion 3 ☐ Removal from Stete Metro Crematory 4/25 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Pneumonia 4 months Examiner, Examiner Muscular Dystrophy
Due to (or es e consequence of): physician and the burief-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending p for use as 88 ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been signed be should be date g 24b. Were autopsy lindings aveltable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed s cartificata has b director, page 2 s 1 ☐ Yes 2 HNo 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4□ Nursing Home 5 Practidence 6 □Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: Al death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 29a. Certifier edical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted. (Check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Apr 24, 1998 lis R 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

Children's National Med Center Washington DC

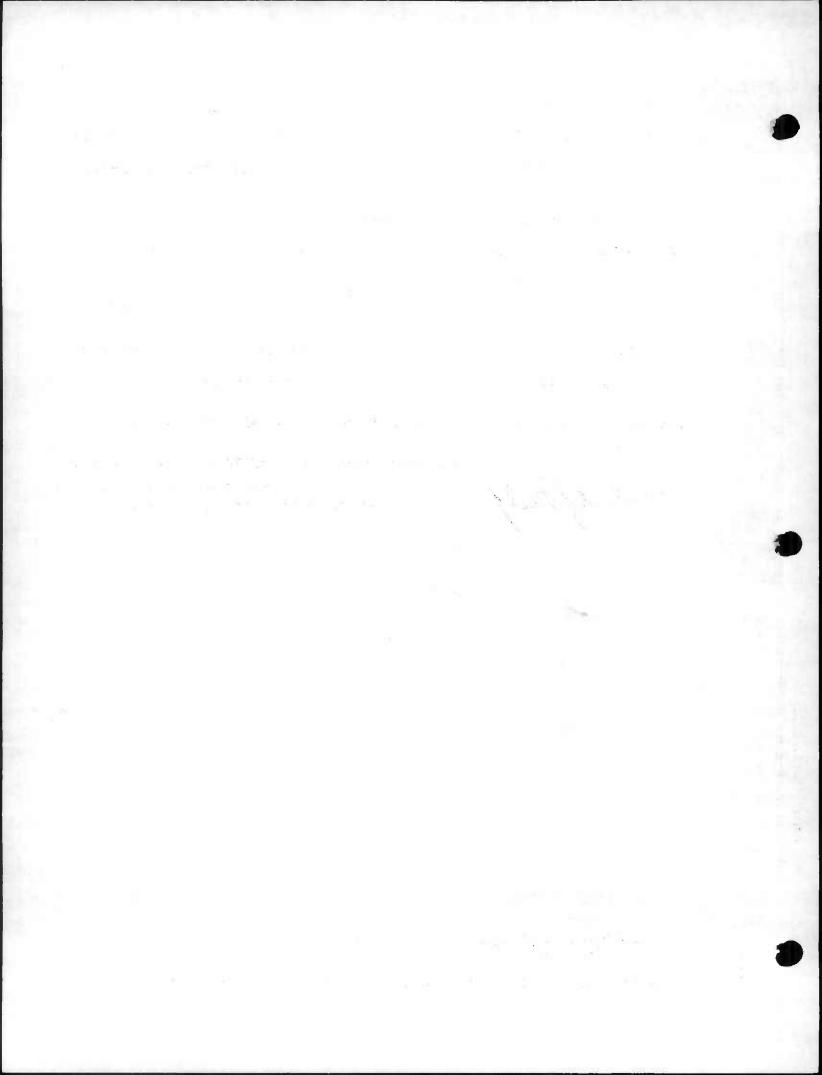
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State of Maryland / Department of Health and Mental Hygiene

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- 3	by	11. Marital Status Y Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedan Armed Forces 1 ☐ Yas 2 ² If Yes, Give Yaer or Dates	No		of Hispenic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	14. Raca Bieck Specify:	- American in K, White, etc.	dien,		
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0	-	30. Neme end eddress of person wh	o completed cause of	deeth (Item 23e) (Ty		- 000		1				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State	Ce	ertificate of			No 98 1	2928
	Physician	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medical	Christian E. Larson				April 1		10:20 a.m.
	Examiner	4a Facility Name (If not institution, give street and			4b. City, Town, or Loc		4c. County of Deat	h
		Johns Hopkins Bayview		-111 11-	Baltimor		N/A	
	Funeral Director	5. Social Security Number 6. Sax 212-05-6868 X M 201	7. Age (In yrs. last birthda) 87 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) June 23,	9. Bin Co 1910 Ma	hplaca (State or Foreign puntry) ryland
aryland	ahow dan	Usual Rasidence of Decedent 10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits 1
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the with the	3a or 28a-f eller be northed	10e. Street and Number 419 South Duncan Street	et	10f. Zip Code 21231			Citizen of What Co	
5-0020 72 hours efter deeth with the Maryland	el, or items 23a or 28a-f ebow Examiner must be notified at by Funeral Director	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Yeer	Decedent Ever in U,S. 13 I Forces? Per 27 No Give 1 Or Detes:	. Was Decedent of H if Yes, specify Cuba 1 Yes 2 1 No	lispantc Origin? (Spe an, Maxican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
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	Hygiene. ther there	4 years 17. Father's Name (First, Middle, Last)	Balti	more City	Fire Figh			re Dept.
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re, N	t of Health and Mantel Hygiene. If Itam 27 is merked other than or other traumatic avent, tra M To Be Comp	20a. Method of Disposition		position (Name of emetory or other place			c. Location - City or	
mor Pages	t: If h	Marial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Om State			1/20/00	Pal+imore	, Maryland
Baltimore,	Depertment of Health Important: If Itam 27 any Injury or other tr pace.	21 Sanatural Educati Camina Linguisa	.// //	22 Name and Addre	er of English			
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Box death certi	attending for use ex	d / -	13 4 2 111 9	CICH		,,,,,,		
O. E	the at formal fo	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause give	ven in Part I.	23b. Did tobe	ecco use contribute	to the cause of death?
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To the Hospital	within 24 hours efter death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: 7	(Check only 2 Medical Examiner: On th	the best of my knowledge, dea e basis of examination and/or nannar stated.					
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	9	Sainder WTul	cause of death (Item 23a) (Type We 2 M.(relet	Klare	Ballo	ine Mes	29222
	State Registrar	31. Date filed (Month, Day, Year) 3:	2 Registrar's Signature	2 me				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Dey **Physician** 22 1998 8:35 A.M. April Loughner Margaret Ann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not Institution, give street end number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (in yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M XXF Months Deys Hours Min. Yrs. Jan. 28, 1942 Pennsylvania 56 Director 207 32 4336 Usuel Residenca of Decedent with the Meryland r 28a-f show 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Gambrills 1 Yes XX No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with and Mental Hydiene.
and of Health and Mental Hydiene.
and: If Item 27 is marked other than natural; or items 23s or in any or other traumatic event, its Mod of 21054 United States 902 Fall Ridge Way Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritel Status Bleck, White, etc. 1 ☐ Yes ★★ No If Yes, Give Year or Detes: 1 Never Merried 25 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: py 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Geographic Administrative Assistant 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ethel Halloran Leo Grimme 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 902 Fall Ridge Way Gambrills Maryland 21054 Gerald Loughner Husband 20b. Pieca of Disposition (Name of cemetery, cremetory or other piece) April 25, Date 1998 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any Injury or o once. Burial 2 Cremation 3 Removal from Stete Maryland National Memorial Park Laurel Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 iplications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, one cause on each line. Part1. Enter the disease, shock, or heart teilure. Li Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner onar Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Bud Due to (or es e consequence ot): P.O. Box 68760. that the death certificets be Physician/Medical Due to (or es e conseque esn esn signed by the a 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 1 108 2 No 3 Probably 4 Unknown Division of Vital Records, þ The law requires 24b. Were autopsy tindings available prior to should I 24e. Wes an eutopsy Completed completion of cause of deeth? irector, page 2 s 1 ☐ Yes 2 ☐ No 201 Physician: 25. Wes case referred to medical exeminer? director Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 3□ DOA 2 ER/Outpetient this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After t 5 Pending investigation or Attending 1 DiNeturel 1 Yes 2 No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end menner stated. \$

31. Dete tiled (Month, Dey, Year) State APR 24 1998 Registrar

29b. Signeture and title of cartifier

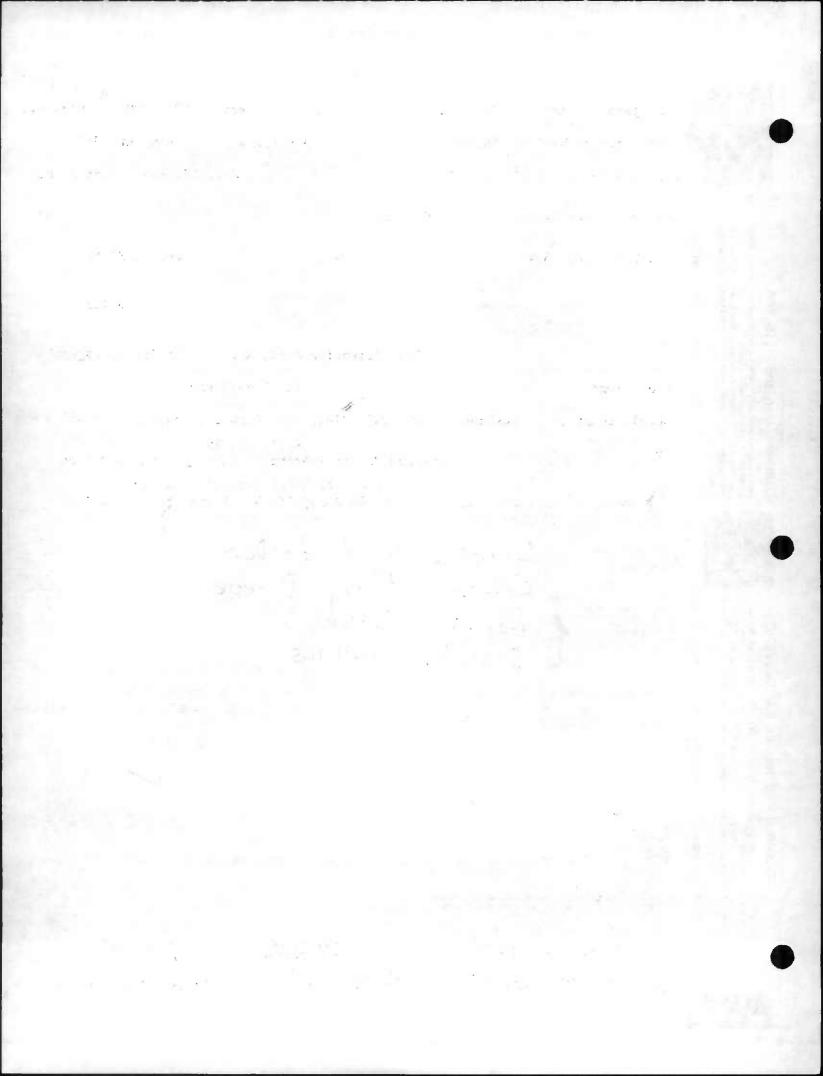
30. Name and address of person who completed cause of death (Item 23e) (Type Print)

Denn's M. Hall (MD) Hall 320 Registrar's Signeture Davidson-Poplate

29c. License number

29d. Date signed (Month, Day, Year)

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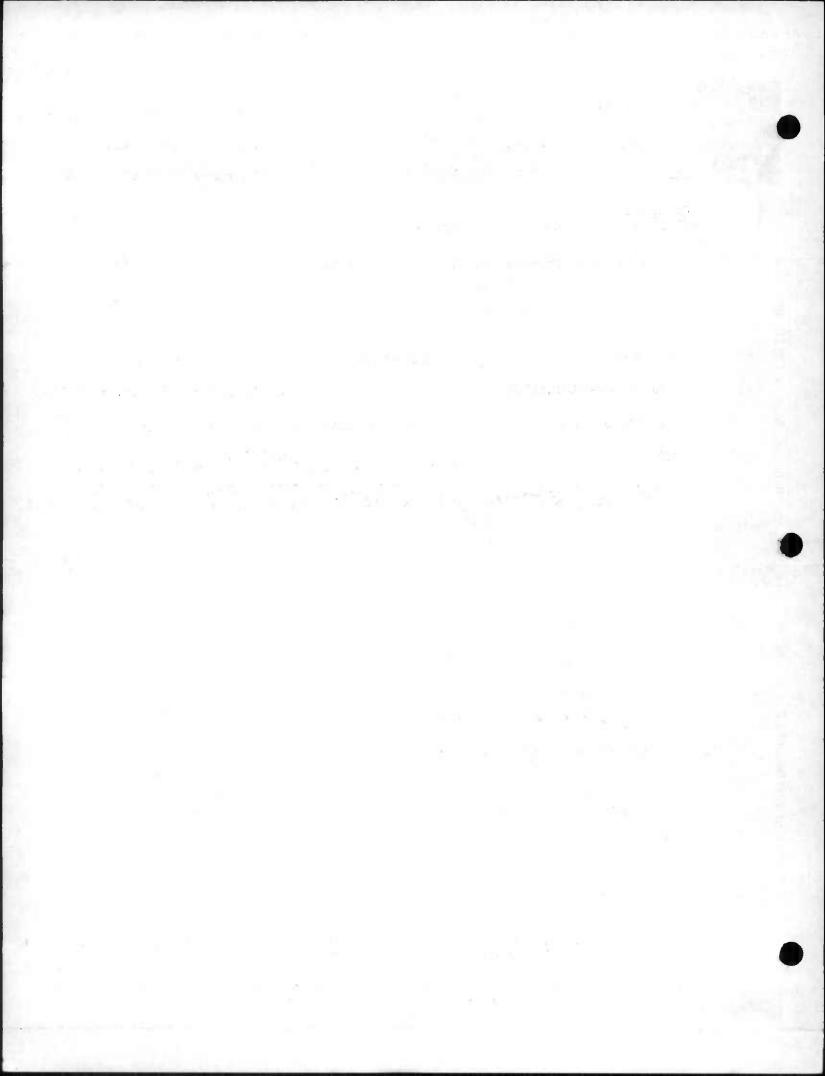
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Ruth Libys April 18, 1998 /Medical 4:15 A. M. 4a. Fecility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Holy Cross Hospital | Silver Spring | Mo: | If Under 1 Yaer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) Montgomery 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplece (State or Foraign Country) **Funeral** Deys 1□M 2√X 98 Yrs. 215-54-7028 Director February 21, 1900 Russia Usuel Residence of Decedant the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryles tent of Healeh and Marel Hygiens. It is that 75 is marked other than "natural", or items 23a or 28a-f show mit it film 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Mades Engine nor must be notified as District XXX es 2□ No Director of Columbia None Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8240 West Beach Terrace, N. W.

11. Marital Status

12. Wes Decodant Ever in U.S.

Armed Forces? Completed by Funeral 20012

13. Wes Decedent of Hispanic Origin? (Specify Yes or Noif Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) S. A. 14. Race - Amarican Indien, Black, White, atc. 1 Yes 2 XXIII Yes, Give Yeer or Detes: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: XWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4th Grade Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumama) Be Leon (Unascertainable) (Unascertainable) (Unascertainable) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Leon Libys - Son 4740 Connecticut Avenue, N.W., Washington, D.C. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Stata permit. Peges Department of Important: If it any injury or once. 4/20/1998 District of Columbia Lodge Washington, D. C. 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 23e. Pert1. Enter the disease, or complications that cause deeth. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final neumonia disaasa or condition resulting in death) Examiner Due to (or es e consequance of) Examiner buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Diseese or Injury that Initieted events rasulting in death) Last Dua to (or as a consequence of) physician s the buriel Box 68760, Physician/Medical Due to (or es e consequence of): 98 use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contributa to the causa of death? P.0. gestive least failure 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? rend insufficiency 24e. Wes en eutopsy performed? Completed page 2 certificete 1 ☐ Yas 2 ☐ No 1 □ Yas 2 □ No **Division of Vital** Hospital or Attending Physician:
 24 höurs after Gath.
 Funeral Director: After this certifice letely in led and another funeral director; 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☑ Inpetient 2 ☐ ER/Outpatlant 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 29e. Certifier 1🗹 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medicai within 24 hg To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dele signed (Month, Dey, Year) 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) old Georgetown Rd. Bethesda Md. David A. B.
31. Dete filed (Month, Day, Year) Blass MO State 24 Registrar

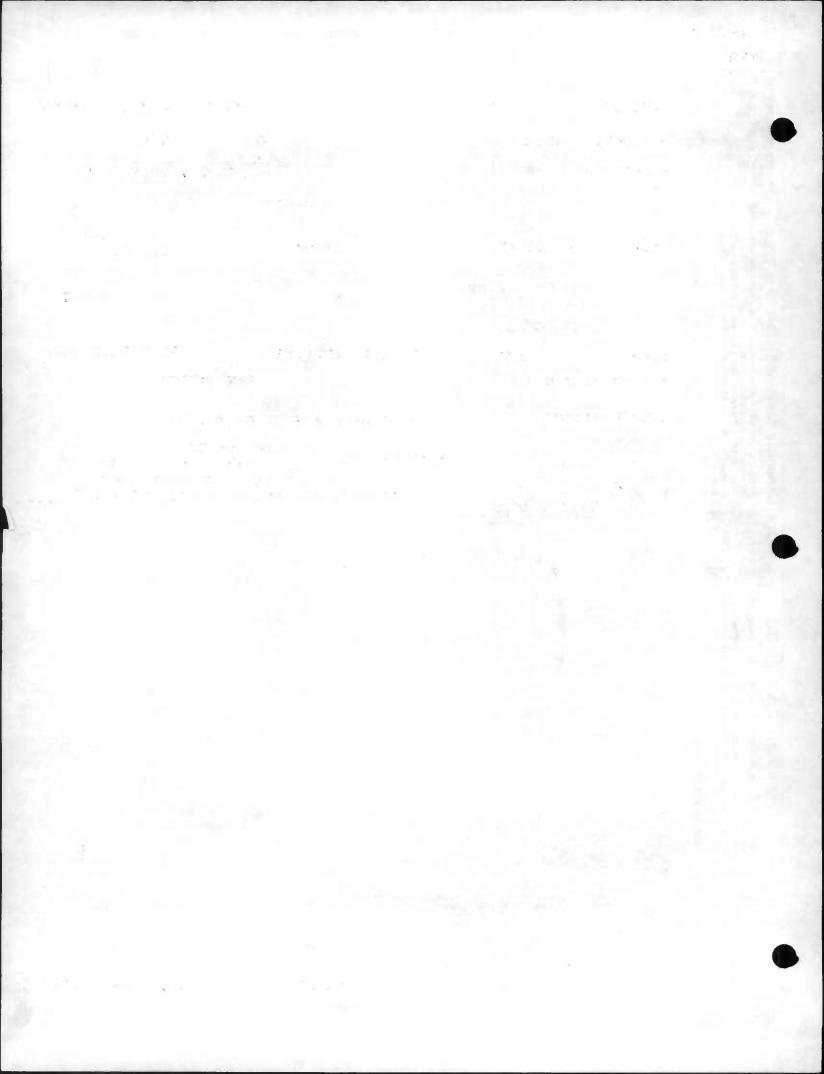


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State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#8 per FH G758 4/24/98 EW 2. Data of Death 1. Decedant'a Name (First, Middla, Last) 7:00 A Month **Physician** /Medical 4c. County of Death 4h City Town, pr ocation of Death acility Name (If not institution, give street and number) Examiner More 100 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Mooth, Day, Year) 1895 9. Birthplaca (Stata or Foraign ocial Security Number 6. Sex **Funeral** 1 M 2 Months Days Hours Min 316-14-8505 Isual Rasidance of Dacedant Director 10a State 10b Count 10d. Instda City Limits the Maryla 1 as 2 No Director 10e. Street and Numba 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or items 23s or the Medical Examiner must be r 30 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) . Was Decedant Ever in U,S. Armed Forcas?

1 Yas 2 No If Yas, Give Yaar or Datas: 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. Pages 1 and 2 should be filed within 72 hours after 1 Navar Married 2 Married 1 Yes 20 No Baltimore, Maryland 21215-0020 Specify þ 3 Widowad 4 □ Divorced Completed 16a, Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) Hygienė. marked other 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Be and Mental mma 2 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print)/5/5/6/ 2 Department of Health a Important: If Item 27 is any Injury or other tre Himore, Md Dorothy 20b. Place of Disposition (Nama of comptent, crametory or other to Date 20c. Location - City or Town, State Method of Disposition 1 Buriat 2 ☐ Cramation 3 ☐ Ramoval from State 4 Donation 5 Othar (Specify) of Funeral Service Licens BBSB, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, to List only one cause on each line. Cive. Approximate Interval Batween Onset and Death **Physician** CAR DIO VASCULAR DISEASE nonth /Medical Immediete Ceuse (Finet disease or condition rasulting In daath) ARTERIO SCLEROTIC Examiner Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cousa (Diseese or Injury that initieted events rasulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Due to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of deeth? 20 NO 3 Probably 4 Unknown ANAEMIA signed t þ 24b. Were autopsy findings available prior to completion of cause of daath? HYPOTHY ROIDISM 24a. Was an autopsy Completed performed' page 2 has 20 No 1 □ Yes 2 □ No 1 Yas After this certificate or Attending Physician: 25. Was casa refarred to medical examinar? Be 26. Piece of Deeth (Check only ona) Hospital: Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of Natural 5 Panding Investigation 1 ☐ Yas 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 21 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicide To the Hospital Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or invastigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner steted. 29a. Cartifiar Medical (Check only one) 29d. Date signed (Month, Day, Year)

31. Data filad (Month Day, Year) APR 24 1998

Juna

29b. Signatura and titla of certifian

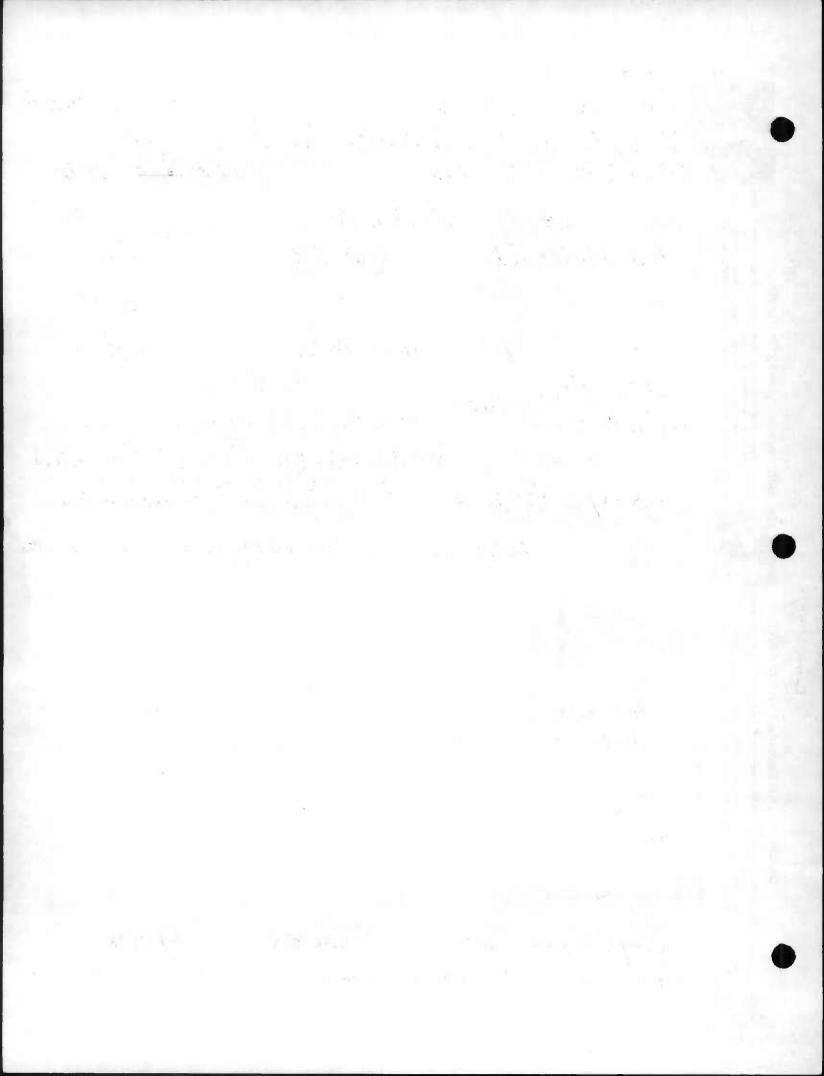
EUTAW ST. BALTIMORE 30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print) SURJIT JUKA MD 821N EU 32. Ragistian's Signature

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29c. License number

21201

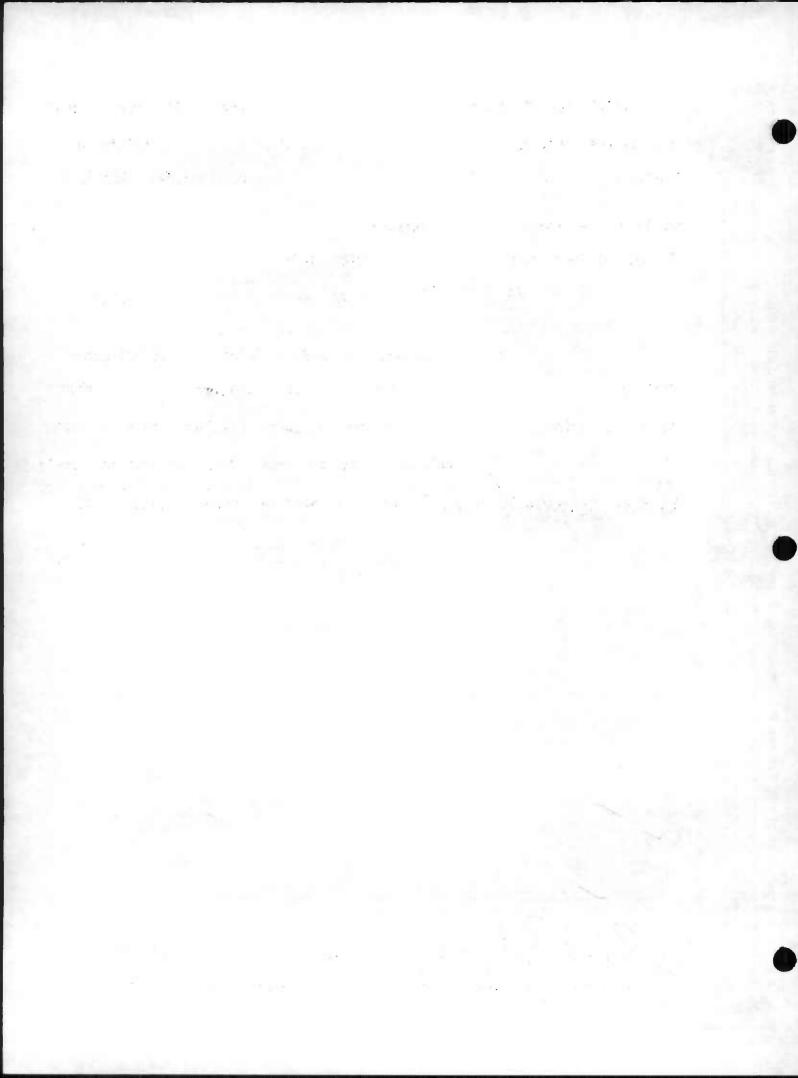
State Registrar



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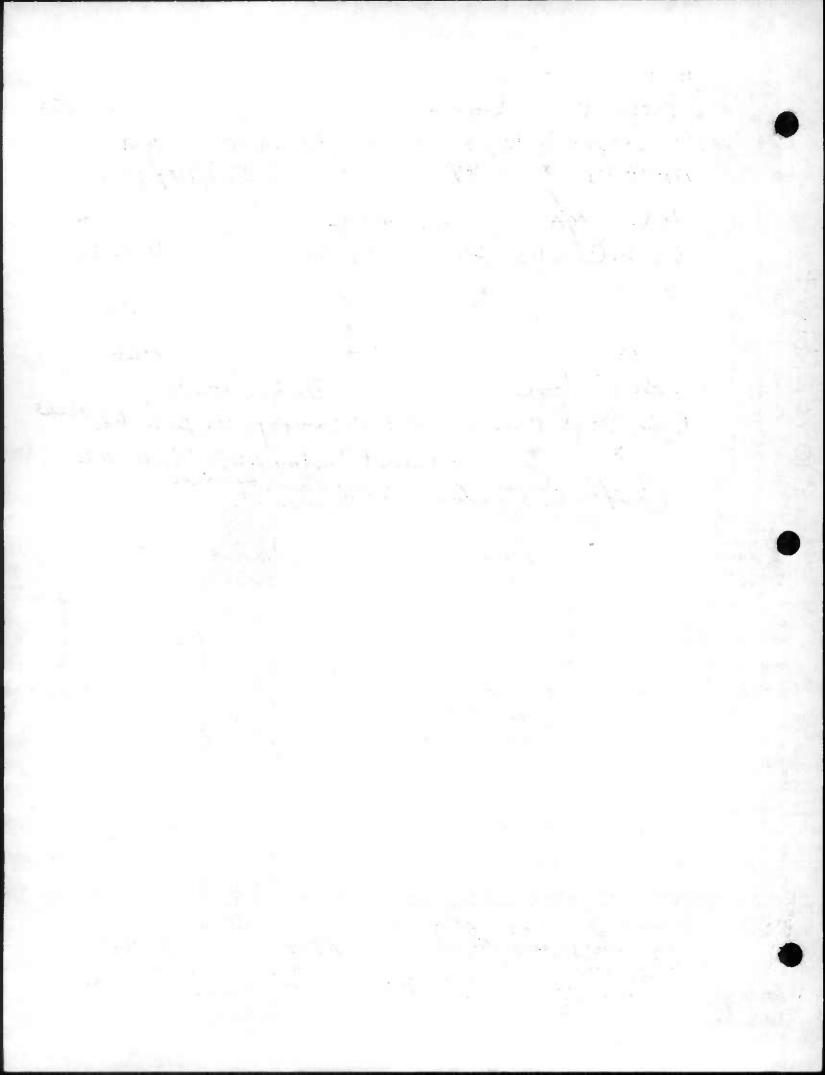
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth April **Physician** FRANK ROBERT MARTNO 1998 2:45PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6711 Queens Ferry Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10M 20F Months Yrs. Director 218-12-2747 September 8, 1924 Maryland Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ehow 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Baltimore 10f. Zip Code 10a. Citizen of Whet Country? I is marked other than "natural", or flams 23s or fraumatic event, the Medical Examinar must be a 21239-1429 6711 Queens Ferry Road USA should be filled within 72 hours after deeth wand Mentel Hygiene. Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grede completed) 16h Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Branch Manager Fleet Sales Truck/Tractor 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Anthony Marino Elizabeth Limmer Jermit. Pages 1 and 2 sk.
Department of Health and N.
Important: If Item 27 is meany injury or other 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Dolores E. Marino Wife 6711 Queens Ferry Road Baltimore, Maryland 21239 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition XXBuriel 2 Cremetion 3 Removel from Stete Donetion 5 Other (Specify) Dulaney Valley Mausoleum 4/24/98 Lutherville, Maryland eture of Funerel Servide License 22. Neme end Address of Fecility Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Per11. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Due to (or es a consequenca # Examiner certificete be executed physician and the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Physician/Medical Due to (or es e consequenca of). 98 use signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? has page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Thesidenca 8 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: Division or Attending 1 Neturel 5 Pending after death. 1 Yes 2 🗆 No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 24 hours 1 🖵 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated. 29a. Certifier Medical To the Host within 24 hb To the Fund completely is 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner steted. (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Dey, Year) MI D-15203 30 Hame end eddress of person who npleted cause of death (Item 23a) (Type, Print) Stephen Busky 600 West Northern Parkway Baltimore, Maryland 21210 31. Dete filed (Month, Dey, Year) APR 2 4 1998 32. Registrar's Signeture State Julia Davidson-Randall

 Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 16a, b per F.H.G-758 4/24/98 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 0650Am 4c. County of Seath apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death **Examiner** Deaton Specialty
5. Social Security Number 6. Sex altimore HOS DITAL + tome If Under 24 Hrs. If Under 1 Year 8. Date of Birth last birthday) Birthplace (State or Foreign **Funeral** Months Days 1 M 2□ F 174-44-630 | Usual Residence of Decedent **Director** filed within 72 hours eftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f show Yes 2□No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 611 Completed by Funeral 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. If item 27 is marked other than "natural", or item or other traumatic event, the Medical Exercises 15€Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Datas: 1□ Yes 2 No 3 Widowed 4 □ Divorced lack 16a. Decedent's Usual Occupation (Give kind of workfoone during most of working life. DO NOT upp retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business industry Elementary/Secondary (0-12) Pagas 1 and 2 should be filed within nent of Haalth and Mental Hygiena. Int: If Item 27 is merked other than College (1-4or 5+) 10 UNKNOWN 1 4 UNKNOWN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gastor oper Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 2034 Balto. Wd. Department of Haalth mportant: If item 27 i W. 92 ousin 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition Data 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses and Address of Facility 1701 McCulloh Part 1. Enter the disease, or complications that ceused he death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final unenoun disease or condition rasulting in death) Examiner Due to (or as a consequence of). Examiner Attanding Physician: The law requires that the death certificete be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate hes been signed by page 2 should be dated 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24a. Was an autopsy performed? 24b. Wera eutopsy findings available prior to complation of cause of death? this cartificate hes Endocardy 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: edicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funaral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Aftar 1 Neturel 5 Pending 1 Yes 2 No death. investigetion by the 2 Accident rector: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) altar A 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and dua to the ceuse(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and title of confiler 29c. Licanse numbar 29d. Date signed (Mghth, Day, Year)

State Registrar



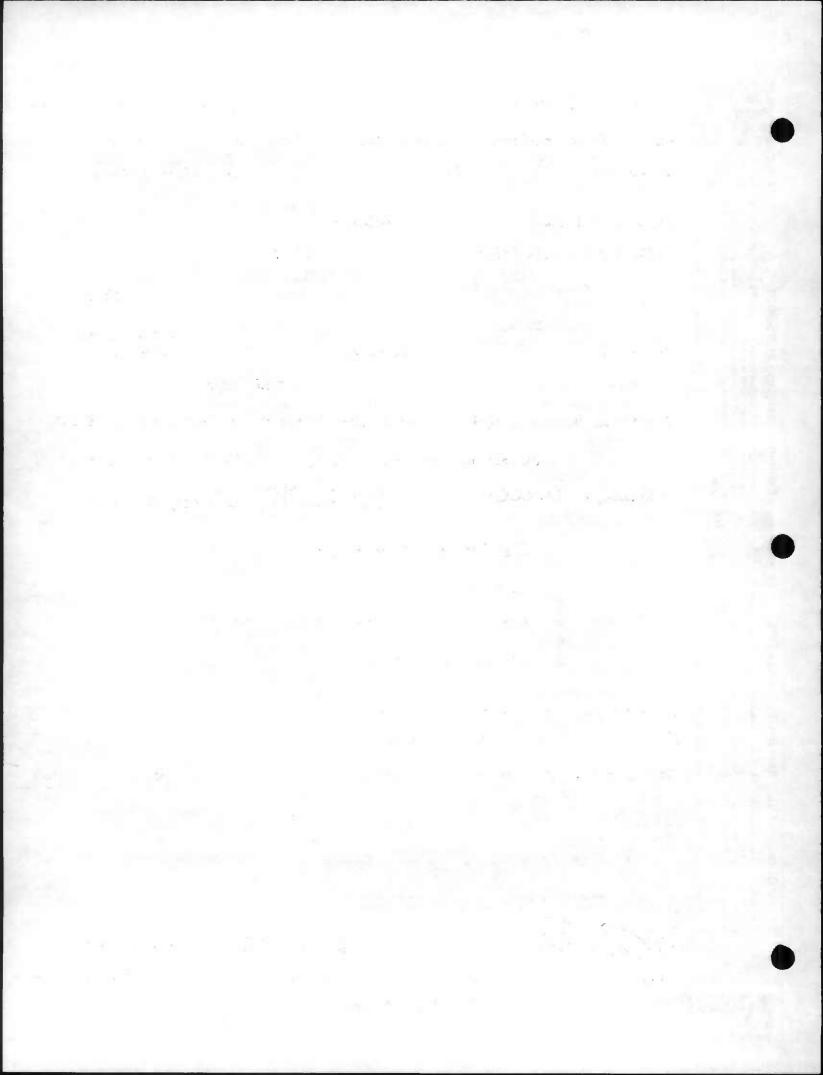
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Frank J. Novak April 20, 5:55 PM 1998 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Genesis Eldercare-Franklin Woods Center Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Jan. 21, 1924 5. Sociel Security Number 6. Sex 1⊠ M 2□ F 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months 216-16-2892 74 Maryland **Director** Usuel Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours efter death with the Maryler neat of Heelin and Mentel Hygiene. Inter of Heelin 27 is marked other than "natural; or freme 23a or 28a-f show ury or other traumatic event, its Mosinea Examens mant be notified as ury or other traumatic event, its Mosinea Examens mant be notified as 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21236 9438 Seven Courts Drive U.S.A. Funeral 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Agricultural Elementery/Secondary (0-12) College (1-4or 5+) Supply Co. Manager 8th grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Joseph Novak Lottei Naja 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9438 Seven Courts Drive, Baltimore, MD Cecilia M. Novak 21236 (wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Gremetion 3 Removel from State 4 Donetion 5 Other (Specify) ENTOMOMENT permit. Pege Department of Important: If any injury or page. Oak Lawn Cemetery 4/24/98 Baltimore, Maryland 22. Name and Address of Fecility 21. Signature of Funerel Service Licensee Schimunek Funeral Home, Inc. Ducin a. Willen 9705 Belair Rd., Baltimore, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician RESPIRATORY FAILURE /Medical tmmediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner ician and burlai-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown TON GUE Division of Vital Records, by 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 s LORONARY ANTENY 1 Yes 2 No 1 TYes 2 TNo certificate funeral director, Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Naturel 5 Pending s after deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide filled in within 24 hours a
To the Funeral C
completely filled Hospital 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 29a, Certifier Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and menner stated. (Check only one) 29b. Significant into of certifier 29d. Date signed (Month, Dey, Year) 29c, License number 31076 Mome end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 68 30 HOSDIFAL OR. BACTO

State Registrar 31. Dete filed (Month, Dey, Year) APR 24



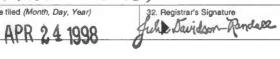


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State of Maryland / Department of Health and Mental Hygiene

		Ce	ertificate of			eg. No.	12936			
Physician	Decedent's Name (First, Middle, Last)				APRIL		3. Time of Death			
/Medical	MILTON L. OHL SR			# Ch T		2 ^{Day} , 19				
Examiner	4a Facility Name (If not institution, give street and number	er)		4b. City, Town, or Lo		4c. County				
	2804 Clearview Ave. 5. Social Security Number 6. Sex 7.	Age (In yrs. lest birthda)	(r) If Undar 1 Year	PARKV:			LTIMORE 9 Birthplace (State or Foreign			
Funeral Director	219-05-0406	81 Yrs.	Months Days		8. Date of Birth (Month, Dey Feb. 22	, 1917	Birthplace (State or Foreign Country) Mary land			
be filed within 72 hours after death with the Maryland of thygiene. d other than "retural", or flems 23e or 28s-f show event, it a Medical Examiner must be notified at event, it a Medical Examiner must be notified at Be Completed by Funeral Director	10a. State 10b. County		10d. Inside City t							
to the part of	Md. Baltimore		Pa	rkville		1 ☐ Yes				
re le	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Country?				
238	2804 Clearview Ave.		2	1234		USA				
is in ryteries of dother than "28a or 28a-f show of dother than "natural; or items 29a or 28a-f show event, it a Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Marriad 2 Married 1 Never Marriad 2 Married 3 Widowed 4 Divorced 12. Was Deceda Armed Force 1 Name of Para Para Para Para Para Para Para Par	□No	. Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2√ No	Hispanic Origin? (Spe pan, Mexican, Puarto Spacify:	ocify Yas or No- Rican, atc.)	e - American Indian, k, White, etc. : White				
ted fet	15. Decedent's Education	16a. Dec	edent's Usual Occu	16b. Kind of Bu	siness/Industry					
aumatic event, the Madical I	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-40)	or 5+)	DO NOT use retire	pation during most of working ad)	ng .					
Con	2yrs		Quality	T			and Cup			
even Be	17. Father's Neme (First, Middle, Last)			18. Mother's Name		Meiden Sumem	e)			
	William Ohl				Delker	O1. =	07.0			
	19a. Interment's Name/Relationship (Type, Print)			t end Number or Rure						
other t	Edna J. Ohl / wife 20a. Method of Disposition		04 Cleary position (Nema of	iew Ave. E			21234 City or Town, Stete			
ŏ	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te cametery, cr	emetory or other ple							
al al	4 Donation 5 Dother (Specify)			Cemetery 4	1/28/98	Owing:	Mills MD.			
ouce	21. Signature of Funaral Service Licansee	.00	22, Nama and Addr.	Eunoval M	ome of F	YA22				
	23a. Part1. Enter the disaase, or complications that caus shock, or heart tailure. List only one cause on eech	sed the death. Do not a	300 Mace	Ave. Balt	more MI). 2122	Approximate			
s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a cons	equenca ot):							
3 6	resulting In death) Last									
for us										
etached for use Physician/A	Part II. Other eignificant conditions contributing to death	iven in Part I.	23b. Did tobacco usa contribute to the cause of death?							
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should should					24a. Was a perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?			
certificate has rector, page 2 be Comp					1□∨	es 2 No	1 ☐ Yes 2 ☐ No			
or. p	25. Was casa retarred to medical			26. Place of Death	(Check only o					
director,	examiner? 1 Yes 2 No Hospital: 1 Input	atient 2 ER/Outpati	ent 3 DOA Ot	ther: 4 Nursing Ho	4.1		er (Specify)			
- H	27. Manner of Death 28a. Date of I	-	ot 28c. Inju		28d. Describe how injury occurred					
atio	1 Natural 5 Pending (Month, 2 Accident investigation	Dey Year) Injury		Yes 2□No						
Certification:	3 Suicide 6 Could not be determined 28e. Pleca ot building,	Injury - At home, tarm, etc. (Specify)	street, fectory, office		treet end Numb n, Stete)	eet end Number or Rurel Route Number, Stete)				
pletely filled edical C	29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination and/or								
W Comp	29b. Signature and title of certifier			sa number	2		d (Month, Day, Year)			
	Michael D. France, m.	0.	D4	10547		APRIL	23, 1998			
							, , , ,			
	30. Name and address of person who completed cause of			- 44						
				es SI. # 3	305, Ba	altimoi	re, mo a1204			

Registrar



DHMH 16 Rev 6/95

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Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Year MARGARET ELLEN O'BRIEN PIERCE April 19. 1998 10:50 AM 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Dulaney Towson Nursing Center Baltimore County Towson If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) 1 M 2 N F Months Deys 214-16-9547 Dec 29, 1906 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21204 111 West Road USA Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Assembly Laborer Canning Company
18. Mother's Neme (First, Middle, Maiden Surneline) 17. Father's Name (First, Middle, Last) Joseph Dora Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Shirley M. (Raughter)

20a. Method of Disposition

1 \(\text{M Burial 2 \(\text{Cremetion} \) 3 \(\text{Removal from State} \) 547 Brooke Road, Towson, MD 21204 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) 4/22/98 Baltimore, Maryland Holy Redeemer Cemetery 21. Signature of Funeral Service 22. Name and Address of Fecility Karty aum Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are startly land 21212 performance shock, or heer failure. List only one cause on each line. Intervel Between Onset and Death (015m Immediate Ceuse (Final Cances. severalyzans diseese or condition resulting in death) Due to (or as a consequence of): 11 Castriki Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Angenia 11 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown poession 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy 1 Yes 20 No 20 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Directo

Funeral

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Completed

Be

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiane. Imprortant: If Item 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it is the contact traumatic event, it is the contact traumatic event.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medicai 88 USB for signed by tha a by Completed Be

The law requires that the death certificate be executed After this certificate has funeral director, page 2 Certification: To

Division of Vital Records, P.O. Box 68760, Attending Physician: death. i or Attendi after death Director: A

28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

(Check only one) 29c. License number 29b. Signature and title of certifier M-D. 1-52205

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 4/21

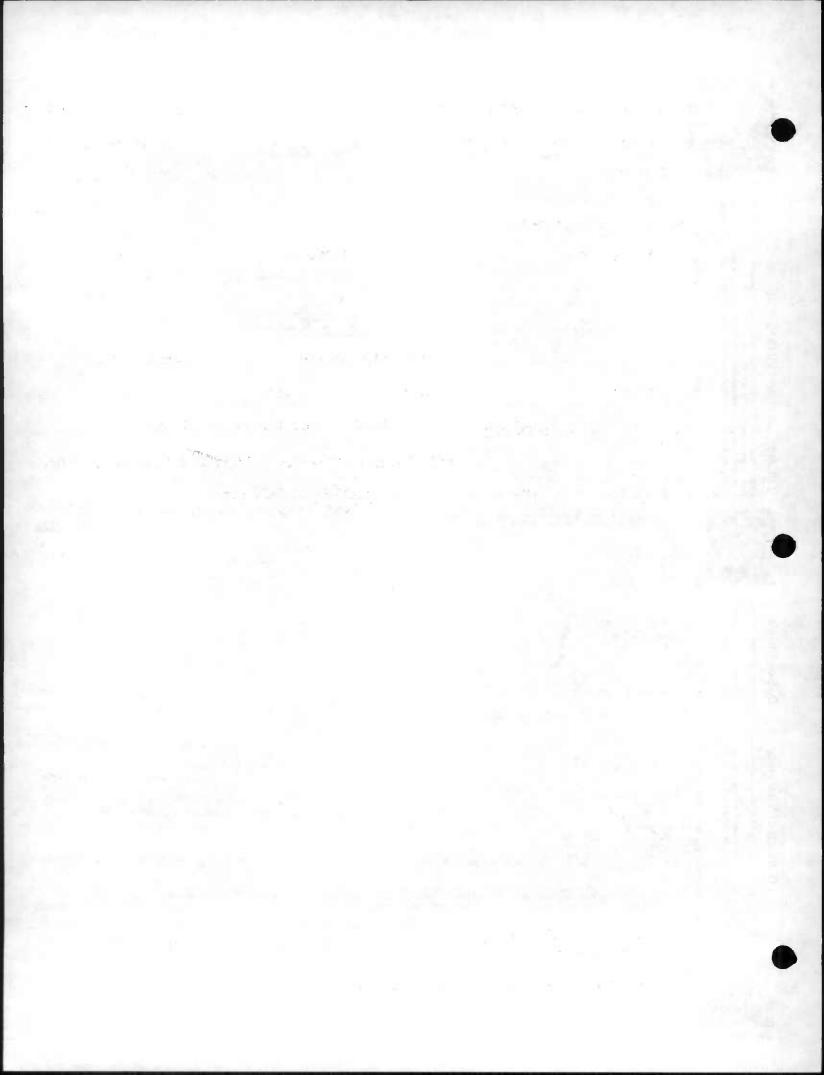
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Yeer) M.D. 1220 S. Hanover St., Baltimore, MD 21230 Pratibha Sharma, 32. Registrer's Signature

Julia Savidson-Randole

State Registrar

edical



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Items: 7.8 per F.H. G-758 4/24/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** APRIL 21, 0. ROY 1998 6:25P /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. lest birthday) | H. Under 1 Year | H. Under 24 Hrs. | 8. Date of Birth AUG. 7 (Month, Day, Year) | 9. Birthplace (Stete or Foreign (Month, Day, Year) | 1910 | NORTH CAROLINA 3510 PHELHAM AVENUE 5. Social Security Number **Funeral** 1 M 2 F 213-10-3852 Director 10a. State
MARYLAND
10e. Stree Usual Residence of Decedent Pagas 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mentel Hygiene.
Int: If Item 27 is marked other than "natural", or item 23a or 28a-f show Jry or other traumatic event, the Medical Examine Trust be notified as 10b County 10c. City, Town or Location 10d. inside City Limits N/A BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3510 PELHAM AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes, Give Year or Dates: DEC. 19, 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 19,422/es 2 No Specify: 1945 14. Race - American Indian. 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: NEGRO by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) STEEL CO. 12TH SHIPPING CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNKNOWN Etta 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES PETTY 3510 PELHAM AVE. BALTO, MD. /SON 21213 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 28, 1998 CEM. OWINGS MILLS, MD. GARRISON FOREST VETERANS 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service Live 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that cau d d shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical FaILURE Examiner Examiner RO SEPSIS physician end s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) ettending pl Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 2X No Renal FailURE 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed Bladden CANCE 24a. Was an autopsy s certificata has b 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Of completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Ager ST Baltimore MO 21202 Berton 1000 tlain 31. Date filed (Month, Dey, Yeer)
APR 2 4 1000 2. Registrar's Signature State Like Davidson Registrar

DHMH 16 Rev 6/95

(alverte la fortie)

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#7 per FH G758 4/24/98 EW Reg. No.-2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 00 Keith Ringgold 22, 98 April of Charity City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Miss. 4c. County of Deeth 818 N. Collington St. Gift of Hope Baltimore NA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1₩ M 2□ F 36 219-80-7725 37 04 - 16 - 61MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits L□Yes 2□No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 818 East Fairmont Avenue 21231 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Teacher Balto. City School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Ringgold Marion Holliday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 19a. Informant's Name/Relationship (Type, Print) 2104 E. Fairmount Avenue Baltimore, Md. Marion Ringgold 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Voshell Mem. Gardens 04-25-98 Dundalk, Md. 22. Name and Address of Facility Baltimore, Maryland 21202 por WM.C.March FH 1101 E.North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirefory erresf, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mycobacterium avium complex infection 17 months Due to (or as a consequence of): 8 years HIV infection Dee to (or as a consequence of): Due to (or as e consequence of) 23h. Did tohacco usa contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

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A 24 hours the Funeral Direction Hospital

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The law requires that the death certificate be associated

or Attending Physician:

Box 68760.

Division of Vital Records, P.O.

Physician/Medical Examiner

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pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Nem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Eventher must be nortified at once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Hospital:

25. Wes case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

26. Place of Deeth (Check only one) 1 ☐ Inpatienf 2 ☐ ER/Oufpatienf 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 28d. Describe how Injury occurred

1 Watural 2 Accident 5 Pending investigation 6 Could not be 3 ☐ Suicide 4 - Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Janua Macya MD 050075 April 24, 1998

30. Namurand eddress of person who completed cause of death (Item 23a) (Type, Print)

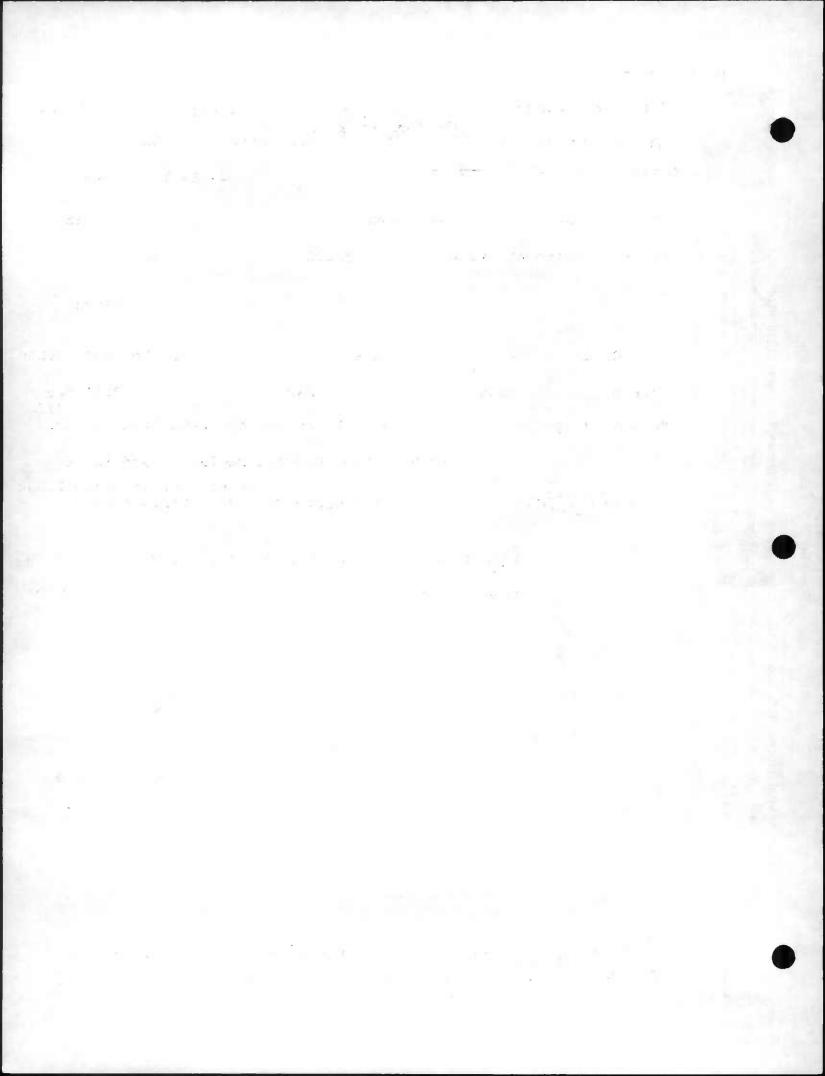
Fanne Maenza, M.O. 1830 E Monment St., #8074, Baymore, MD 21205

1 TYes 2 No

31. Date filed (Month APR 2 4 1998

wisioner Burdson Anders

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Day Year 22 1998
4c. County of Deeth **Physician** Reig /Medical 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Examiner Shore Howard 6007 If Under 24 Hrs. Green 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. Dete of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2×F Months Deys Hours Min 246-03-7905 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f ahow any lollury or other traumatic avent, the Medical Examine must be notified at 10d. inside City Limita 10a State 10b. County 10c, City, Town or Location 1 Yes 2 No unbia Director Howard 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A 6007 21045 by Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Was Decedent Ever in U.S. 14. Rece - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1□Yes 2 No Black Baltimore, Maryland 21215-0020 Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grede completed) 16b. Kind of Business/Industry partment Elementery/Secondery (0-12) College (1-4or 5+) 13 th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Hice 0/eu Hood 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Service N.C. 28645 Funeral enion = Dony 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date important: If In any injury or o Buriel 2 Cremation 3 Removal from State Greensboro 4 □ Donetion 5 □ Other (Specify) Approximate
Interval Between
Onset and Death Wabash 0 Do not enter the mode of dving, such as cardiac or respiratory errest the disease, or complications that caused art failure. List only one cause on each lin **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical recurrent 1 year Examiner Due to (or as e consequença of) Physician/Medical Examiner years Hypertension Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Breust cancer Susperted 1-2 years Due to (or es e consequenca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Dementici by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy Completed Eutherroid - thyroid nodule page 2 No 1 ☐ Yes 2 ☐ No Kecent Gastroentestinal bleed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2♥ No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner es stated.

[2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier

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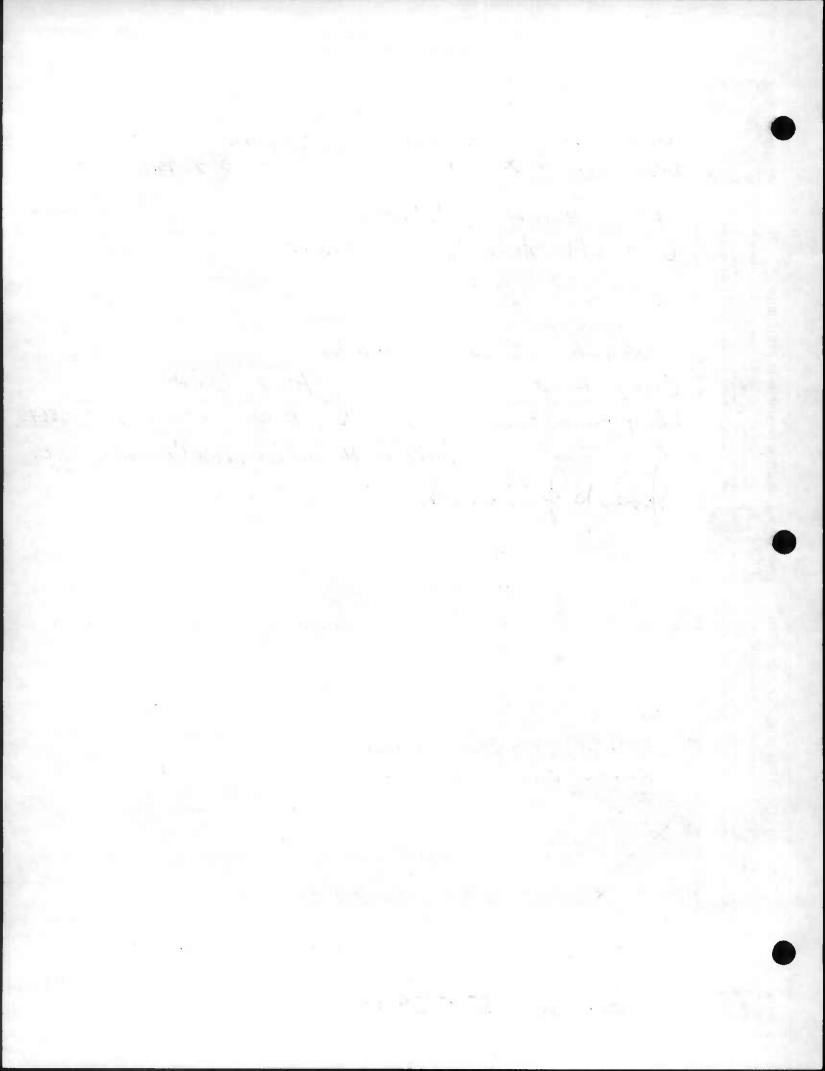
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31. Dete filed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (item 23a) (Type, Print)

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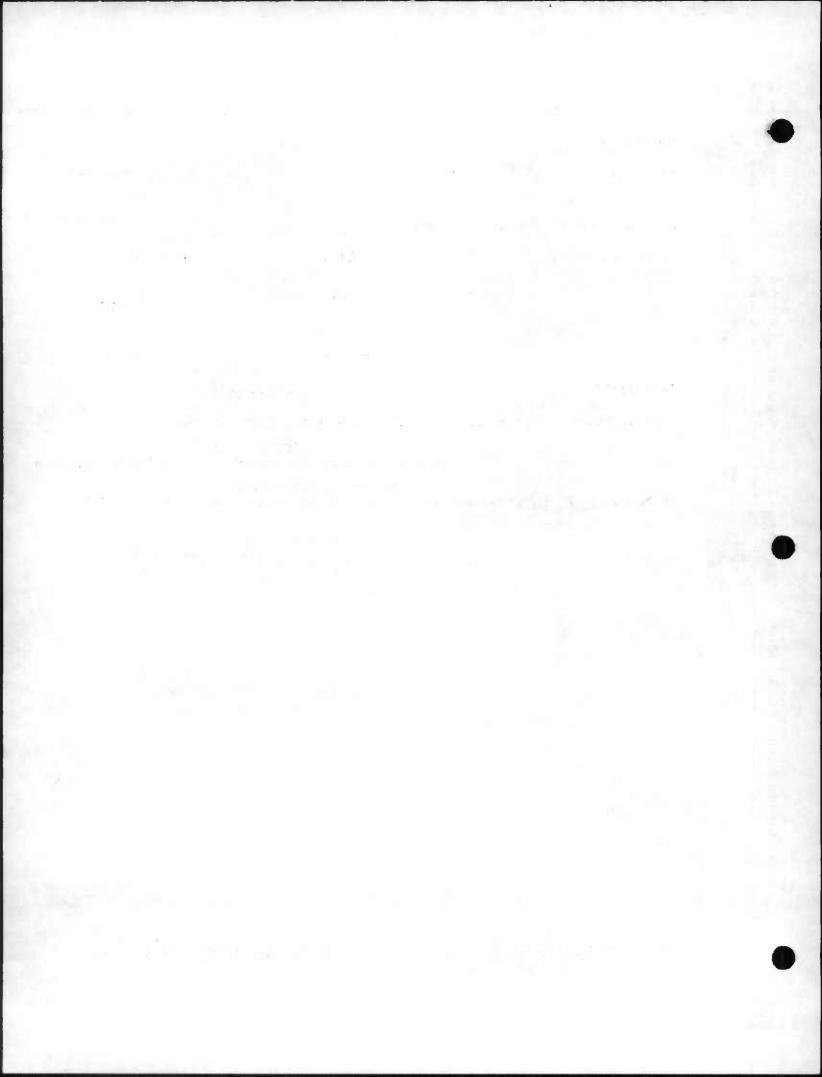


State of Maryland / Department of Health and Mental Hygiene)
State of Maryland / Bopartmont of Floatin and Montal Hygiene	9

Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1.00pm D. 20 1998 Alice Randa11 April /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's 12500 Hemm Place Bowie If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (Stata or Foraign Country) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Yrs Director 214 35 8988 88 Aug. 16,1909 | Scotland Usual Residence of Decedent with the Marylend 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12500 Hemm Place 20716 Great Britian Funeral deeth 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 200 No tl Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritei Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or hereny Injury or other trauments. Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2√No Specify: þ 3√Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Cotlege (1-4or 5+) Elementary/Secondary (0-12) 12 Receptionist Medica1 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Unavailable Janet Reid 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. informant's Name/Reletionship (Type, Print) Jean J. Miller Daughter 12500 Hemm Place Bowie Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or othar place) April 21 3 to 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Northern Virginia Crematory Arlington Virginia 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funerel Service Licensee 16000 Annapolis Rd. Bowie Maryland 20715 Ø 23e. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical immediate Cause (Finat anest - ASCVD disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner rence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be datac 1 Yes 2 No 3 Probably No Unknown þ 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24a. Was an autopsy page 2 2 No 1 Yes 2 No 1 Yes certificata Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Chack only ona) exeminer? Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Coutd not be To the Hospital or Atta-within 24 hours after de-To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOO 57325/M trekelm 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 2200 BAHEMI MD DEFENSE COST BHAWNA 32. Registrar's Signature 31. Date filed (Month, Day, Year) MD 21114 State Julia Davidson-Randalle Registrar

DHMH 16 Rev 6/95



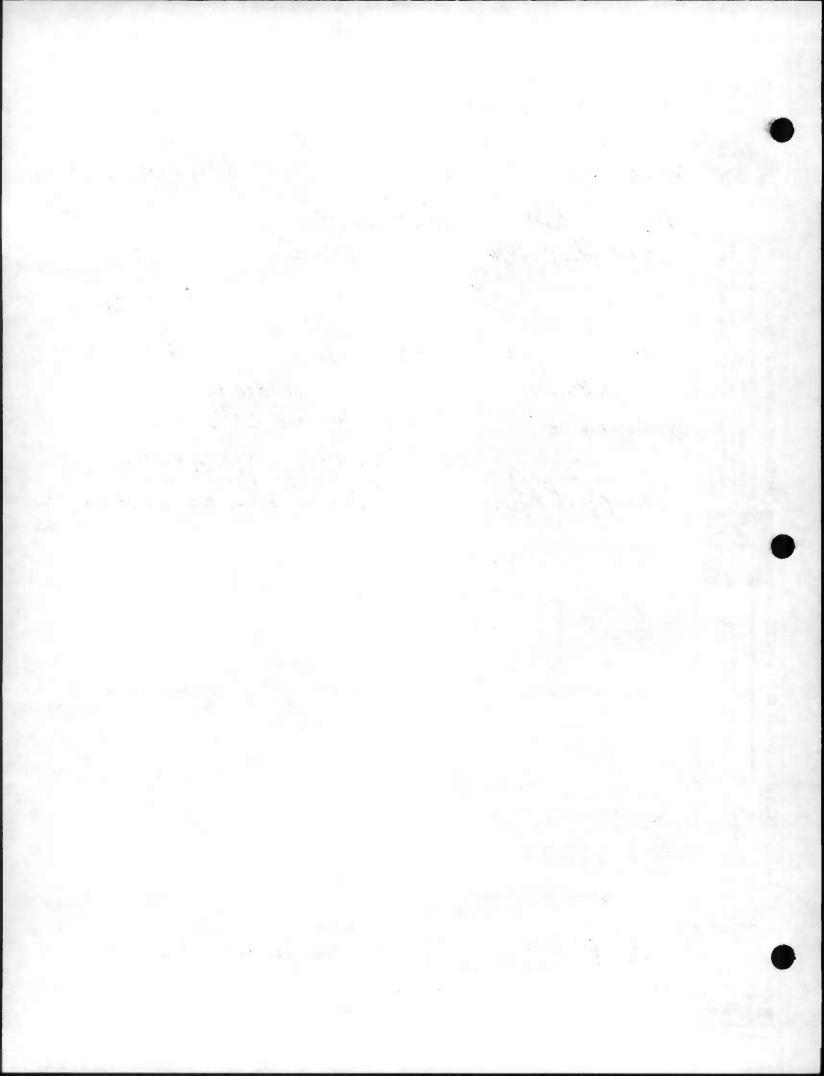
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State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate o	f Death		Reg. N	lo. 9 0	1	191	12		
Dhualala		1. Decedent's Nama (First, Middle,	Last)					2. Data of Month	Death	Dey	Year	3. Tima	a of Death		
Physiciar /Medica	_	ELEANOR	JOSEPHIN	E	R	EIST		APRIL		21	Yaarq 8	0	858		
Examine	- 4	4a. Facility Name (If not institution,						n, or Location of D		lc. County					
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s 23a or	Funeral Director	8800 Walther Blvd. /			21234			10g. Citizen of What Country? USA							
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"natural",	etec	15. Decedant's Education (Specify only highast grada completed)			16a. Dece	dant's Usual Occ	of working	16b.	Kind of B	usinass/indu	stry				
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Merke To Tatio	2	Charles Ey		Γ		Marie									
Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mesonics. To Be Commit		19a. Informant's Name/Ratetionship Arthur Reisz (Son)							i Route Number, City or Town, State, Zip Coda) 1801 Baltimore, Maryland 21234						
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int: H		1 ☐ Burial 2 🖾 Cramation 3 4 ☐ Donetion 5 ☐ Othar (Spe		Meta	ro Crema	etary, Inc.	April 2	22, 1998	Balt	timore	, Maryl	Land			
Departmen Important: any Injury once.		21. Signeture of Funeral Servica Lic	ansea		22	2. Nama and Add	ress of Fecility								
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the day	Completed by Physician/	Part II. Other significant conditions	contributing to death	but not rasul	Iting in tha u	nderlying causa	givan In Part i.	23b. D	oid tobacc	o usa co	ntributa to t	he caus	e of death		
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page page								1	□ Yas	2 No	10	Yas 2	No		
director, pag		25. Was case refarred to medical examinar?					26. Place o	f Death (Check on	ly one)						
00	0	1 Yes 2 No	Hospitel: 112 Inpat	iant 2 E	R/Outpatier	nt 3 DOA	othar: 4 Nurs	ing Homa 5□R	a <i>s</i> idanca	6 □Oth	ar (Specify)				
		27. Mannar of Deeth	28a. Data of Inj					28d. Descri	28d. Describe how Injury occurred						
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8 5 8		29a. Cartifiar (Check only Amedical Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.										a(s)			
within 24 h To the Fur complately		One	and mannar s	stated.											
2 C C C	5	29b. Signatura and title of certifiar	JENNIFOR !	BENLY,	MD	29c. Lica	nse number		29d. D	ate signe	d (Month, De	ey, Yeer)		
) UM	RESIDENT			Res	- 000		Ar	RIL	21,19	9			
	-	30. Nama and addrass of person wh				Print)									
		JENNIFER BERRY M	1000		TAU /	4900 04	STERAL	MENUE /	241 T	11/201	E MD	2	1224		
State		31. Dete filed (Month, Day, Year)		trer's Signati	-	117-011	7 - 14 /		01101	שייושיין	- (
State		APR 2 / 1000	della Sui	מל											

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Shuter 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner SINAI HOS DIT A of Baltimore BAltimore If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthpiece (State or Foreign **Funeral** 1□ M 2 F Deys Hours Min 77 Yrs. **Director** Usuel Reside permit. Pagas 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified. 10e. Stete 10b. County 10d. Inside City Limits 1 Has 2 No Funeral Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 6608 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes: 14. Race - Amarican Indian. 11. Merital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Newer Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be INKNOWI UNKNOWN P The Pro Viden 19b, Meiling Address (Street end Number or Rusal Rouge flumber, City or Town, Stete, Zip Code) 6608 Mrs Mary Marine 20b. Place of Disposition (Neme of Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Ramovai from Stete 100 4 Donation 5 Other (Specify) Pert1. Enter the disease, or compications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heert failure. List only one cause on each line. Approximata intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finei disease or condition resulting in deeth) Sepsis Examiner Due to (or es a consequence of): Examiner pullar CANCER physician and the bungleransit Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760, RENAL FAILURE Physician/Medicai Dua to (or as a consequence of): The law requires that the death certificating 80 use signed by the a 23b. Did tobacco usa contribute to the cause of death? Pert tt. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Unknown 1 Yes 2 No 3 Probably à 24b. Were eutopsy findings available prior to completion of ceuse of deeth? should 24a. Wes en eutopsy Completed irector, page 2 s 2 X No 1 Yes 1 Yas or Attanding Physician: director, 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 inpatient 2 ER/Outpetient 3 DOA NOYes 2□ No this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Aftar 5 Pending investigation Naturei 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after deat Director: 6 Could not be determined 3 Sulcide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A within 24 hours after To the Funeral Director Completaly filled in by 29e. Certifier (Check only one) Cortifying Phystolan: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of gurtile 29c. Licensa number 平249 AJ414735 30. Neme and eddress of person who completed cause of death (item 23e) (Type, Print) ISAAC Milchell Hospital SINAI 31. Dete filed (Month, Day, Year) 32. Register State APR 2 4 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death 19, 1998 5:30 AM James A. Shannon April 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Dea 3600 W. Franklin Street BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrş. last birthday) Birthplace (Stete or Foreign /Country) Deys 1**X** M 2□ F 216-12-290 Yrs Usuel Residence of Decedent 10b. Count 10d. Inside City Limits Maryland yes 2□No more 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2122 12. Wes Decedent Ever in U.S. Armed Forces? Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Merried 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify 3 ₩ Widowed 4 Divorced Hro-American 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 17. Fether's Neme (First, Middle, Last) 7eorge phannon 19a. Informent's Name/Rejetionship (Type, Print) 19b. Meiling Address (Street end Number or Rure! Route Number, City or Town, Stete, Zip Code) Mar Mc Afee 10. 20b. Place of Disposition (Neme of semetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Dicenses 22. Name end Address of Eacility 401 North 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory or heart failure. List only one cause on each line. Ave Approximete Intervel Between Onset end Death Immediate Ceuse (Fine) Myocardial infarction diseese or condition resulting in death) minutes Due to (or es e consequence of) Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

signed by t

peed has

certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica

filled in by the

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Completed

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Certification:

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2 Accident

29a, Certifier

Physician

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Examiner

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Director

7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Madical Examiner mass

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

the Maryland

Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest Physician/Medical

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. congestive Heart Failure

Chronic Obstructive Pulmonary Disease

1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No

Hypertension, Hyperlipidemia 25. Was cese referred to medical

Hospital: 1 XYes 2 No 27. Menner of Deeth 5 Pending investigation 1 Neturel

APR 24 1998

28e. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29c. License number

26. Plece of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 1🖄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

29b. Signature and title of certifier

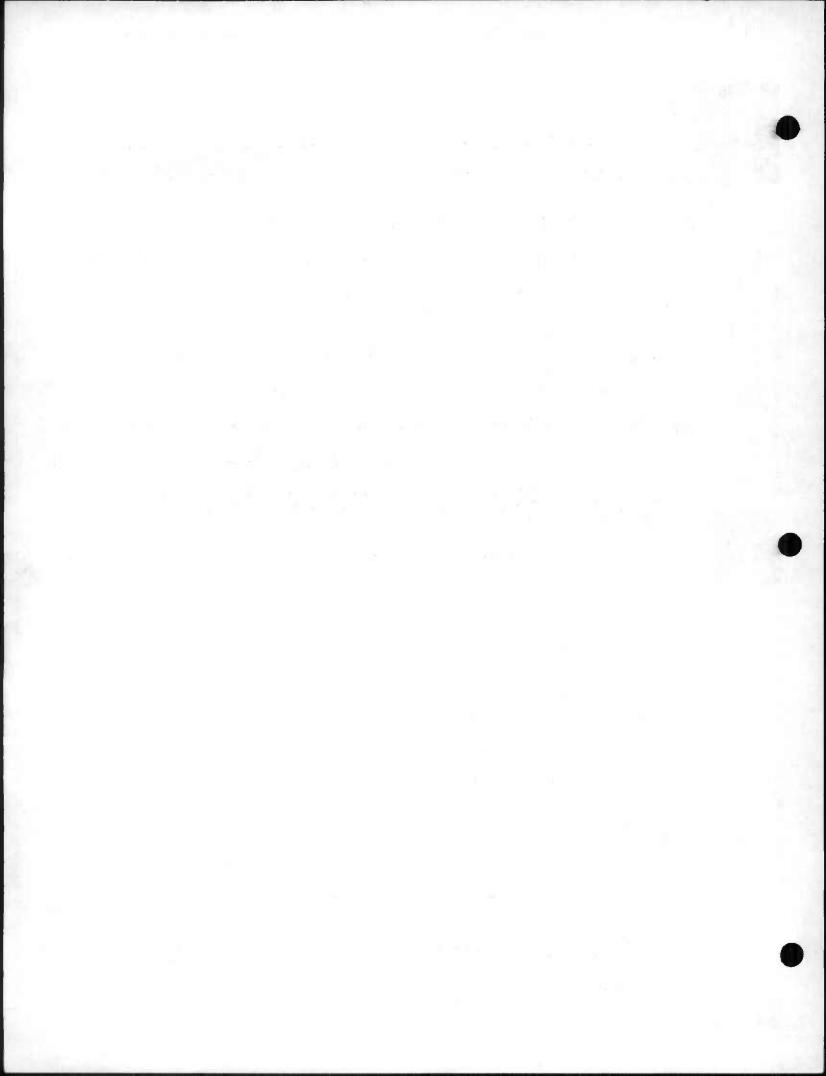
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

David Tasker, M.D., 10 N. Greene Street, Baltimore, MD 21201 31. Dete filed (Month, Dey, Year)

State Registrar

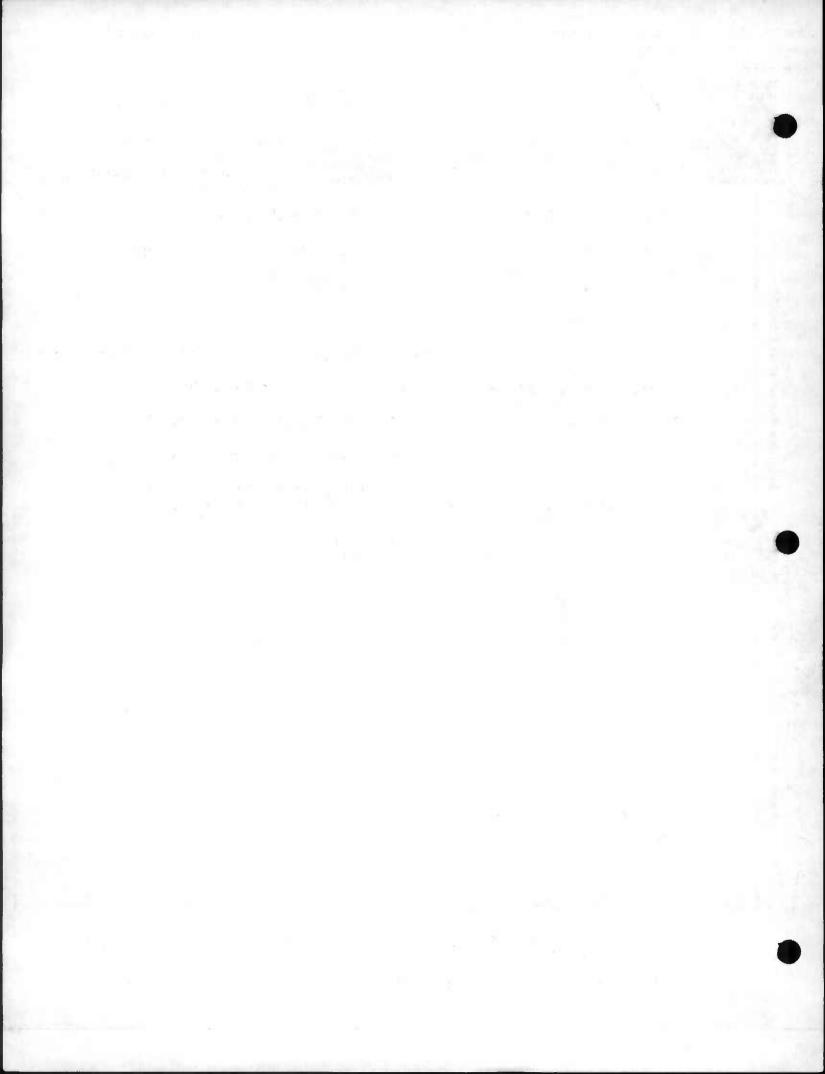




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State of Maryland / Department of Health and Mental Hygiene 8 2945

						(Certific	ate of	Death			Reg. No.																
Physician		1. Decedent's Name (First, Mic		spangl	er						2. Date of De Month	Day 2 /	Year /9 9 8		me of Death													
/Medical Examiner		la. Facility Name (In not institu	ion, give	street and number	·)				4b. City, To	wn, or Lo	cation of Deat		unty of Death															
LAditilie		Suburban Ho							Ret	hesd	a		Montgo	mer	,													
Funeral	-	5. Social Security Number	6. Se		ge (In yrs.	last birtho		der 1 Yea	r If Under	24 Hrs.																		
Director	-	212-32-6867 1□ M 2□ F 62 Usual Residence of Decedent				Yr	Yrs. Months Days Hours Min.							9. Birthplaca (State or Foreigr Country) estVirginia														
No w	10a. State 10b. County 10c. City, Town or Location											10d. Ins	ide City Limits															
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To To	2	Frederick L. Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Ma						Sadie L. Windon ling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)																				
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Department of important: If I any Injury or once.		21. Signature of Funeral Servi		11	ĵ	1	Con	2011	ress of Facility Fune	ral I	Home of	f Esse.	×															
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:= 0		examiner? 1 ☐ Yes 2 No		Hospital: VC Other:							5 ☐ Residence 6 ☐ Other (Specify)																	
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To the comple		29b. Signature and title of carti	fier	. /				29c. Lice	nse number			29d. Date s	igned (Month	n, Dey, Y	eer)													
		I found	/ (frela		_		0	1779	/		April	22,19	98														
	3	30. Name and address of personal A	Hold			n 23e) (Ty	/pe, Print)	14.1	1 Rd	, R.	ec levill	le, mo	20.	851														
State	:	31. Date illed Month, Dey, Ye	10	22 Ponte	rar's Signa	trand	ese																					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 26 per M.D G-758 4/24/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Mary N. Stroh April 17, 1998 9:00PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 4407 Lobelia Road Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Deys Hours Yrs. Dec.25,1911 Director 173-03-5721 86 Lancaster, PA Usuel Residence of Deceden the Maryland r 28a-f show 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 munt be Items 23a 4238 East Joppa Road 21236 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus r than "natural", or Item the Medical Examiner should be filed within 72 hours after and Mental Hygiene.

merked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Board Elementary/Secondary (0-12) College (1-4or 5+) 9th. of Education n/a Cafeteria Worker traumatic evant. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Benjamin Hackart 2 Anna Bleacher 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health and it if item 27 is no other traum Mr. William G. Stroh (Son) 4407 Lobelia Rd. Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1

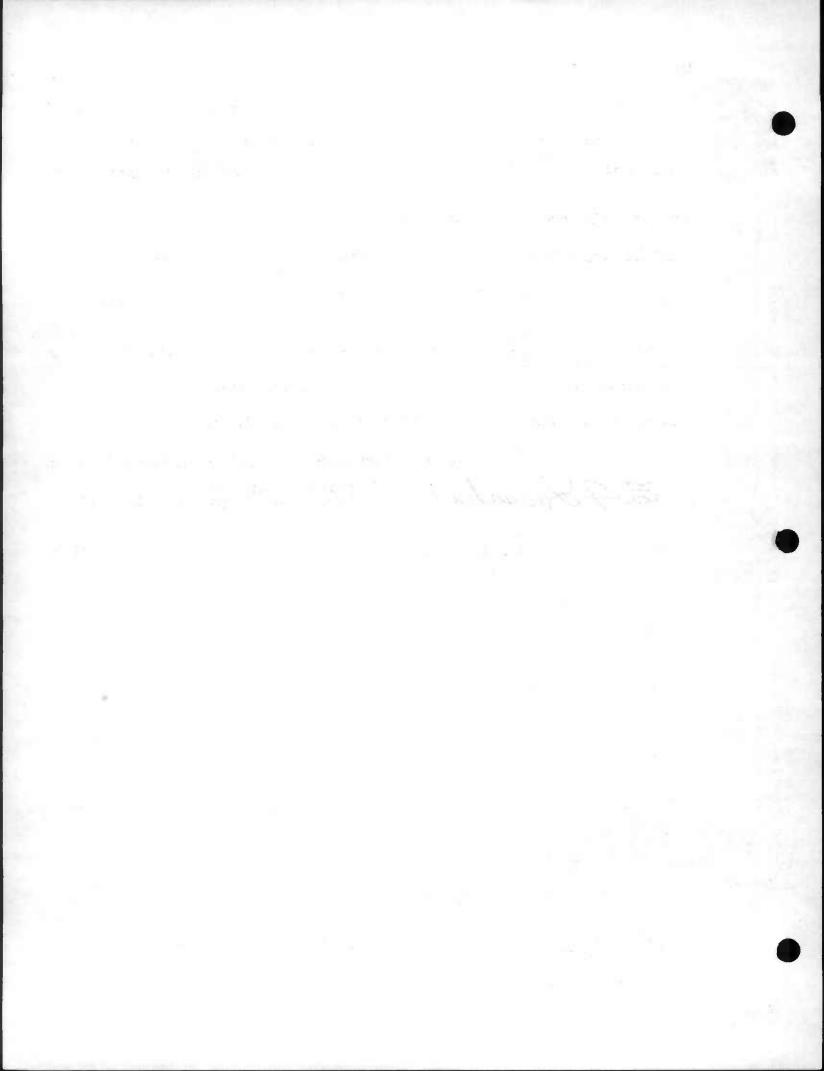
Burial 2 □ Cremation 3 □ Removel from Stete permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 4/21/98 Baltimore, Maryland 21. Signeture of Funerel Service Licens 22. Name end Address of Fecility E. F. Lassahn Funeral Home sa 11750 Belair Road Kingsville, Md. 21087 23a. Pert1. Enter the disease, or confiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) **Examiner** ue to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): De exec P.O. Box 68760. that the death certificate å Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 1 ☐ Yss 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed 1 be del Records. þ The law requires 24b. Were eutopsy findings eveileble prior to Be Completed 24a. Wes en eutopsy performed? completion of ceuse of deeth? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No on of Vital 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sons Home 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Pris 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending Investigetion 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner as steted. 29a Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 8 To the and menner steted. To the 29b. Signature end title of certifier 29d. Pate signed (Month, Day, Year) 30 Nem of deeth (Nem 23a) (Type, Print)

Coxold hop

7636 Belain Rd.

21236

State Registrar 31. Dete filed (Mont



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month April Helen B. Summers 1998 12:05 P.M. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth Baltimore Baltimore Eastpoint Nursing If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27, 1898 7. Age (In yrs. last birthdey) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 1 M 20X F Months Deys Michigan 99 Yrs. 133-16-9358 Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Insida City Limits 1 X Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 U.S.A. 601 Wyanoke Avenue 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: White 3 🕽 (Widowed 4 □ Divorced 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 6th grade Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Mary Sproch Paul Fedak 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) 21040 Eleanor Akehurst (Niece) 1831 Steven Drive. Edgewood. MD. 20b. Place of Disposition (Neme of camatery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Buriel 2 X Cremation 3 ☐ Ramoval from Stata 4/23/98 Green Mount Crematory Baltimore. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Road, Bel Air, Maryland 21014 Tolund 23a. Part1. Enter the disea , or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth MOREARY ARREST Immediate Ceuse (Finel disaasa or condition resulting in deeth) LMUTRITION Due to (or es e consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events rasulting in death) Last EMBHTIA Due to (or es e consequenca of): OBSTRUCTIVE CLIMG DISEASE 23b. Did tobacco use contribute to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown 24b. Were eutopsy findings sveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 212 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 28. Piece of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Department o Important: If any injury or

Physician

/Medical

Examiner

10a State

Directo

Funerai

þ

Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland neal of Health and Mental Hyglans. Annt: if fear 27 is marked other than "naturel", or items 23s or 28s-f show th: if them 27 is marked other than "naturel", or other traumetic event, the Modical Examiner must be notified at

3altimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medicai 88 esn

signed by the a been si

requires that the death certificate be executed certificate has t After this funeral

Division of Vital Records, P.O. Box 68760,

by Completed Be 2 Certification:

Medicai

27. Menner of Deeth

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

5 Pending

6 Could not be

investigation

 Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After the To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the

> State Registrar

28b. Time of

Pleca of fnjury - At home, farm, street, fectory, offica building, etc. (Specify)

28e. Date of Injury (Month, Dey Year)

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end manner stated. 29c. Licensa number 29d. Data signed (Month. Day, Year)

28d. Describe how injury occurred

29b. Signeture and title of certifiar

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

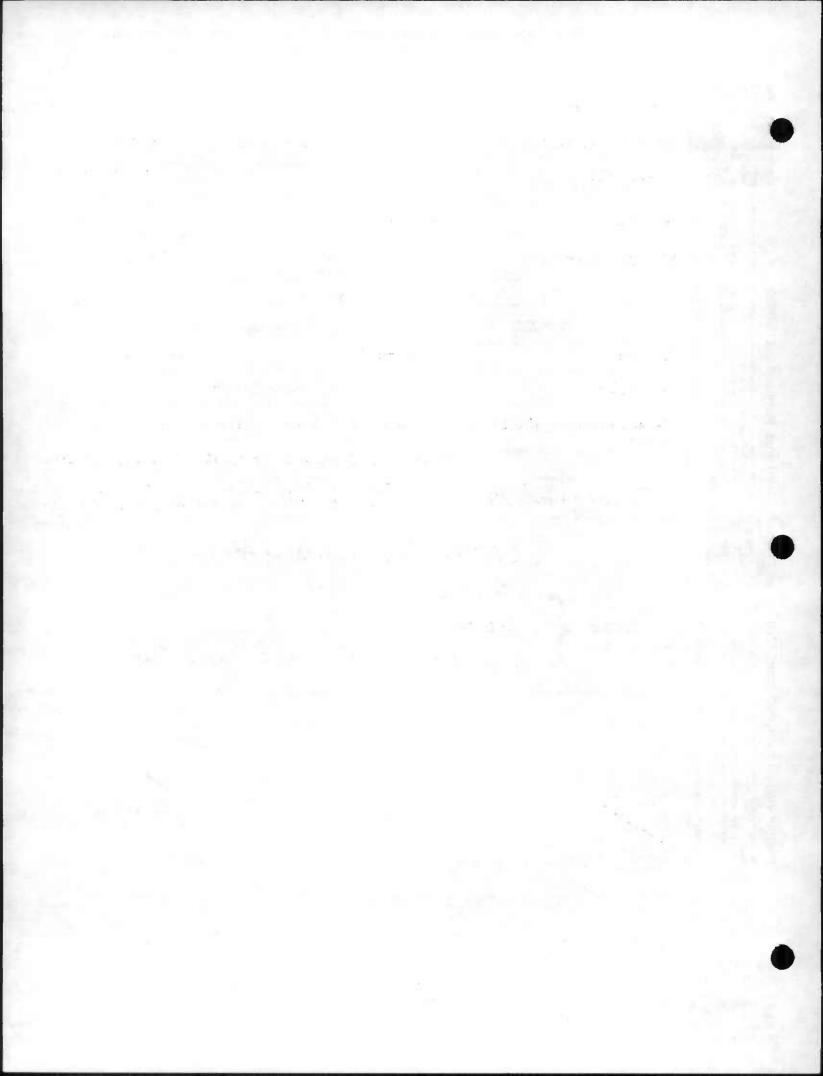
98

Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrate Signature
Fulia Davidson Randall

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Lest) Month Dev **Physician** 17, 1998 5:30 P.M. Inez Elizabeth Smith April /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Crofton Convalescent Center Crofton Arundel If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2FKF Months Deys Hours Min Yrs. Director 577 26 9297 83 July 10,1914 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Experiment must be notified at Ange. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏖 🔽 No Director Maryland Queen Annes Stevensville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 625 Cloverfield Drive 21666 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes & No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes €No Specify: Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School Board of Elementary/Secondary (0-12) College (1-4or 5+) Dietician Prince George's Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Henry Best Katie Catherine Sutton 2 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 625 Cloverfield Drive Stevensville MD 21666 William L. Smith Son 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) April 21, petel 298 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Brentwood Maryland Fort Lincoln Cemetery 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 21. Signeture of Funerel Service Licenses 23a. Pent Enter the disease, or complications, or heart failure. List only on 16000 Annapolis Rd. Bowie Maryland 20715 ations that caused to a cause on each line d the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Interval Between Onset end Deeth **Physician** ALZHEIMER'S DiSease /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be exacuted physiciam and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings avelleble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? certificate has b 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) funeral 27. Mepher of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Naturel Accident 5 Pending investigation r death. 2 No 1 Yes Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) end manner stated. 29a. Certifier edical (Check only one) 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

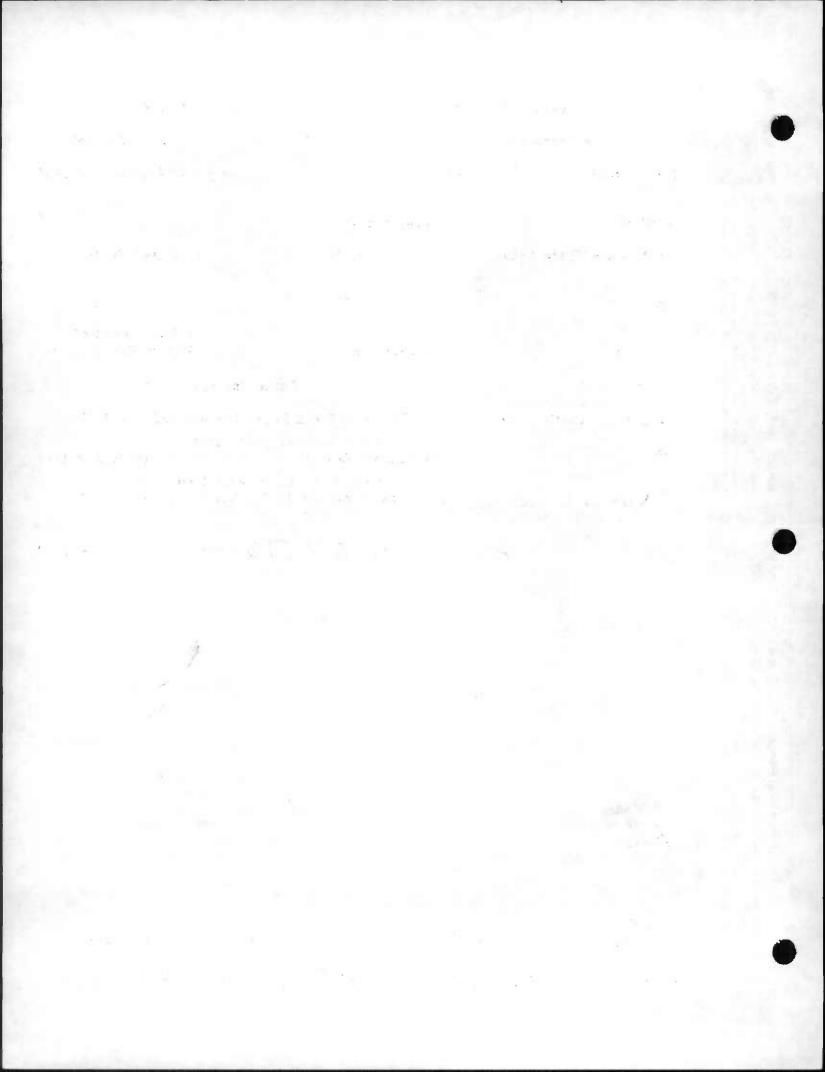
APR 24 1998

31. Dete filed (Month, Day, Year)

Ka

14300 Gallant Fox Lane Bowie MD 32. Registrer's Signeture which Tavidson- Randall

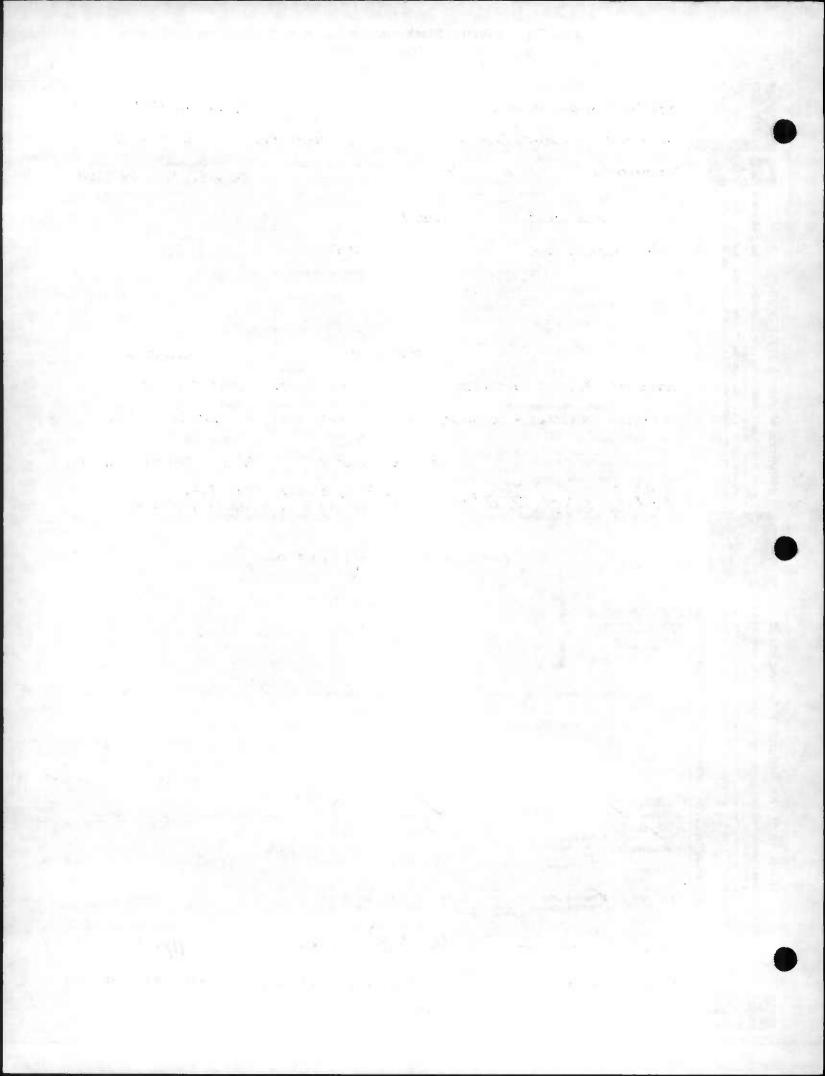
30. Name end edd;ess of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death April 22, 1998 **Physician** 1323 Myrtle Virginia Skinner /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Undar 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 218-42-6046 95 Yrs. Director Feb. 14, 1903 Maryland Usual Residence of Decedent with the Marylend 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yas 2 No MD Anne Arundel Harwood Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, if a Medical Examiner must be a 4460 Lansdale Road 20776 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s eny Injury or other traumatic event, tra Medical Examiner reserva-Funeral 12. Was Decedent Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, Whita, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Elliott Catterton Mary Amanda Bassford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Skinner - Daughter 4460 Lansdale Road, Harwood, MD 20776 Marjorie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodfield Cemetery 4/25 Galesville, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 21401 Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical Myocandiel in larction Examiner Examiner the death certificate be executed physicien end the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 98 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 □ Unknown 1 Tyes 2 No that signed t Division of Vital Records. þ The law requires 24b. Wera autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? i certificata hes t 1 ☐ Yes 2 E No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case refarred to medical examinar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpetient this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 29a. Certitier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number mill ny Ma F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B(ROLTTA E MILLER 8601 VETERANS HIGHWAY, MILLERS VILLE MI).

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🤶 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month 1998 APRIL 21 8:32 A.M. CARITA GALLAGHER SMITH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE FRANKLIN SOUARE HOSPITAL CENTER ROSEDALE If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 10/8/21 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpleca (Steta or Foreign Months Days Hours 1 M X F 216-12-3897 Yrs MARYLAND 76 Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE PARKVILLE 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21234 USA 8820 WALTHER BLVD. APT. 2203 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indten, Bleck, White, etc. 1 X Never Merried 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) Eiementery/Secondary (0-12) College (1-4or 5+) MILITARY CONTRACTOR 12th GRADE INSPECTOR 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) CARITA M. GALLAGHER LAWRENCE A. SMITH 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) SHARON CHRISTIE NIECE TIMONIUM, MD 21093 19 BLONDELL COURT 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stata 4/24/98 BALTIMORE, MD PARKWOOD CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name end Address of Fecility JOHNSON FUENRAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD It. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel RESPIRATORY FAILURE Due to (or es e consequence of): CHRONIC OBSTRUCTIVE PYLMONARY DISEASE 10 YEARS Due to (or es e consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings avaltable prior to 24e. Wes an autopsy performed? completion of cause of death? 28 No 1 Yas 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

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this certificate

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of Attending Physician: effer deeth. Director: After this certifica

To the Hospital o within 24 hours of To the Funeral D completely filled I

by

Completed

Be

P

Certification:

Medical

The lew requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

filed within 72 hours after death with the Maryland

Hygie

Pages 1 end 2 should be fill ment of Health end Mentel Hant: If Itam 27 is marked out

permit. Pages 1 end 2 Depertment of Health e Important: If Itam 27 is any injury or other tra once.

Baltimore, Maryland 21215-0020

el Hygiene. other than "natural", or frams 23a or 28a-f ahov vent, the Macical Examiner must be notified at

Examiner Sequentially list conditions, if eny, leeding to immadiate causa. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Lest Physician/Medical

diseesa or condition resulting in death)

Pert It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Deeth

Neturel

3 ☐ Sulcide

2 Accidant

4 Homlcide

28e. Dete of Injury (Month, Dev Year) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

29a. Cartifier (Check only one)

5 Pending Investigetion

6 Could not be determined

Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the best of exemination and/or investigation, in my opinion, deeth occurred et tha time, dete and plece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier Welsen MD

APR 24 1998

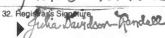
29c. License number D38327 29d. Data signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

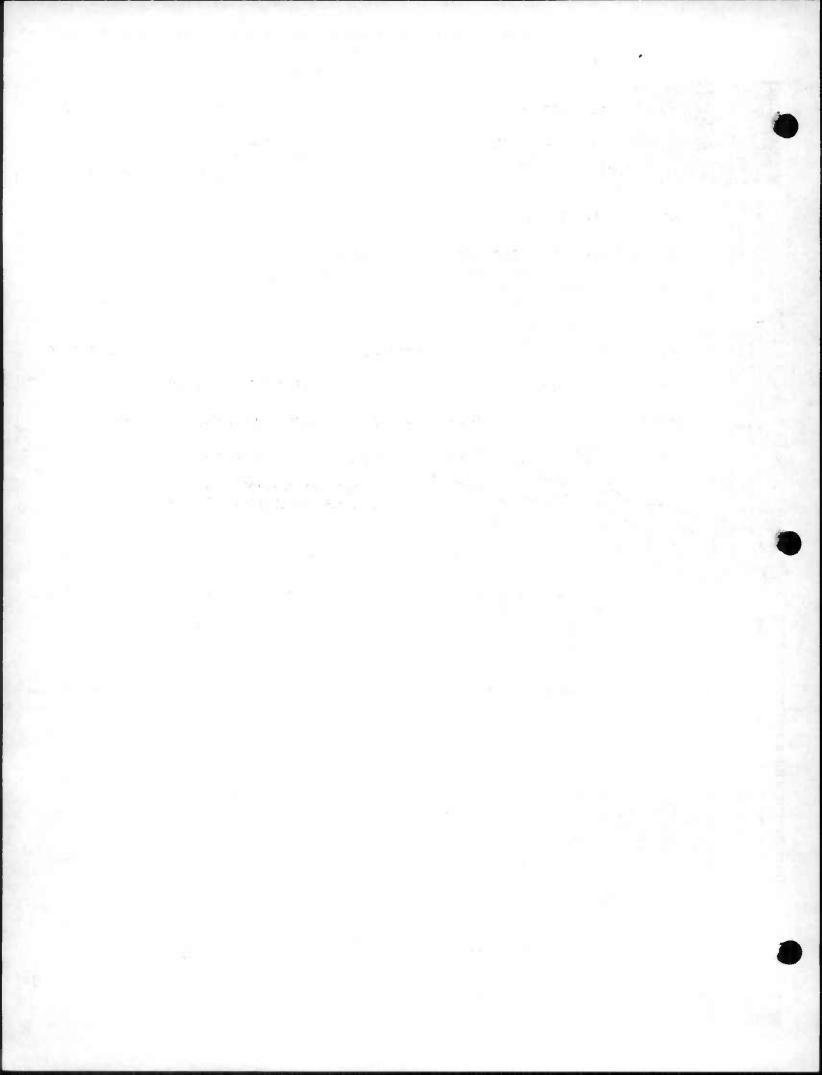
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

YORK ROAD, SUITE #18; LUTHERVILLE, MO 21038 LOIS E. NIELSEN, M.D. 1205 31. Dete fited (Month, Day, Year)

State Registra

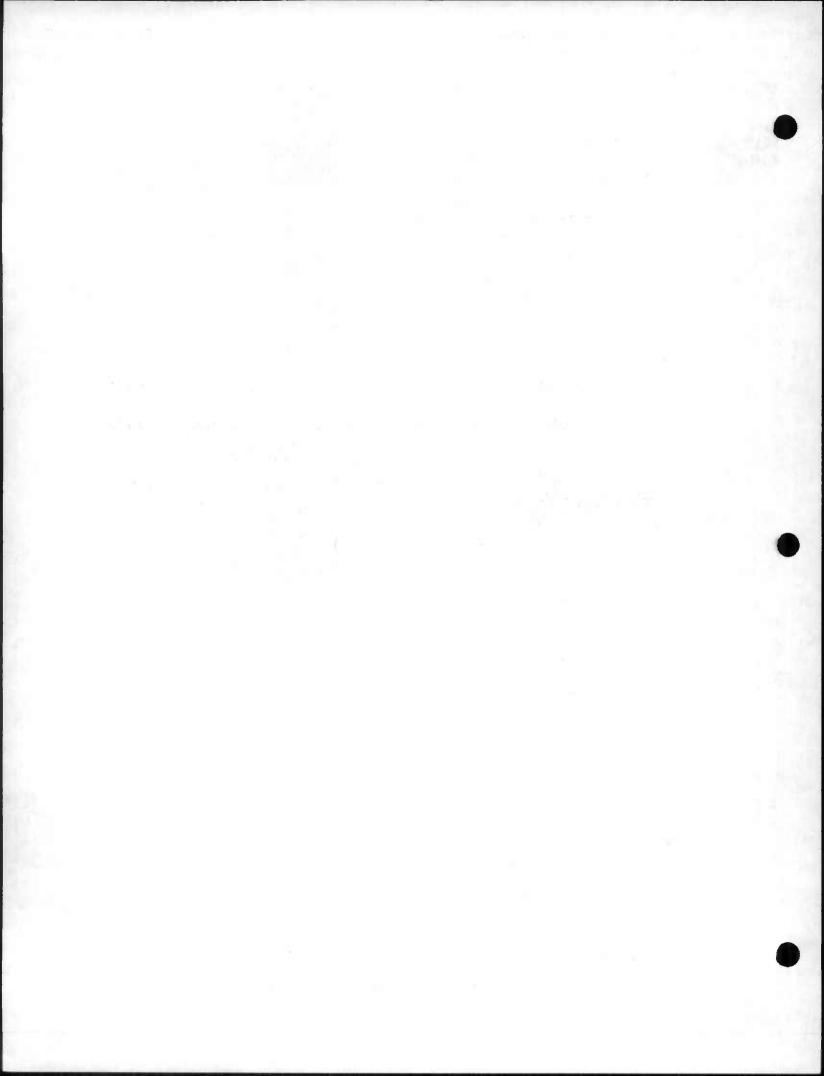


28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	ai yiai i	-	ificate of	Death		Reg. No.	}	295	1
	Physici	an	1. Decedent's Neme (First, Middle, Le						2. Dete of Dee	eth Day	Year	3. Time of	Deeth
	/Medic		Leonard J.	Scharf			1		April	22 19	998	8:40	PM
	Examir	ner	4e. Fecility Neme (If not institution, gi	e street and number)				4b. City, Town, or					
_			3449 Yorkway				R.Hd A.M	Dundal			timo		
	Funerai Director		220-32-3561	Sex 7. Age	6 (In yrs. 59	lest birthdey) Yrs.	Months Deys				9. Birthpl Count MD	lece (State or try)	Foreign
	how		Usual Residence of Decedent 10a. Stete 10b. County		10c. City	y, Town or Loc	ation				10	0d. Inside Cit	y Limits
	e Ma	cto	MD Balt:	more	I	Dundal	k					1 🗆 Yes	2 € No
	or 28)ire	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Vhet Count	try?	
	23a	ai	3449 Yorkway				2122	2		USA	À		
020	ges 1 and 2 should be filed within 72 hours eftar death with the Maryland to Chaelih and Mentel thygiene. If Itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent & Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:			es Decadent of I Yes, specify Cub	Hispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rec Bled Specify	a - America ck, White, e		
0	2 ho	Pe	15. Decedent's E	ducation		16e. Decede	nt's Usuel Occu	pation		16b. Kind of Bu	usiness/ind	Justry	
218	hin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	4)	(Give k	ind of work done O NOT use retire	during most of word)	rking				
7	d with	mo;	12	College (1-4013	Τ)	Fore	man			Steel	L		
D	should be filed vand Mentel Hygies marked other turnetic event, to	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Ne	me (First, Middle,	Meiden Sumem	ie)		
la	uld b Vent rked rice	Tof	Henry J. Schar	rf				Casim	ira E.	Myslir	ıski		
lan	sho and l		19a. Informent's Neme/Relationship	Type, Print)		19b. Meiling	Address (Stree	end Number or R	ural Route Numbe	er, City or Town,	Stete, Zip	Code)	
2	and salth		Clementine Scl	narf /wi	fe	3449	Yorkw	ay Ba	ltimore	, MD 2	11222	2	
ore	of He		20e. Method of Disposition	D	20b. P	lace of Disposi	tion (Neme of etory or other pla	ay Ba ∞)Cem. Jesus	Dete 2 E	20c. Location -	City or To	wn, Stete	
Ĕ	Peg nent int: H		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		Sac	red He	eart of	Jesus	1998	Baltin	nore,	, MD	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 si Depertment of Haalth an Important: if Itam 27 is r any injury or other traur		21 Signature of Juneral Service Ligar	70		22.	Neme end Addre Connell	ss of Facility Y Funer	ral Home			lk	
			23a. Parti Enter the disease, or con	plications that caused	the deeth	Do not enter	7110 Sc	llers F	Point Re	d 2122	2	Approximete	
	Physician		23a. Part Enter the disease, or con ships, or heart failure. List only	ceuse on eech lin	e.			9,				Intervel Betw Onset end D	veen
d.	/Medical	1	Immediete Cause (Finel	Mot	2ct	tic	Ma	lanon	0		1	10 ~	-tt-
	Examiner		disease or condition resulting in deeth)	e. 11C1	Due to (e	r es e consegu		janun	79		1	101	IUMIN
		Je.			Due to (o	es e consequ	erice oi).				4		
	ificata be elacuted g physicien and es the buriel-transit	Examiner	Sequentially list conditions	b	Due to (o	r es e consequ	enca of):						
o ·	1 5 E		Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury								1		
68760,	ita be iysici	edicai	thet initieted events resulting in deeth) Lest	c	Due to (or	es e conseque	ence of):				-		
	E 0 0		resolving in deedily Lest								İ		
Вох	th cert endin	an		d									
	that the death cert ed by the attending detached for use	Physician/M	Pert II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the und	derlying cause gi	ven in Pert I.	23b, Did t	obacco use cor	ntribute to	the cause o	f death?
0.	that the led by th detache	Phy							10	Yes 2 No	3 Prob	ably 4 l	Unknown
Ś		by											
Division of Vital Record	law requiras that as been signed to 2 should be det	De le								en eutopsy med?		ere eutopsy fi	
BCC	m 07 CV	Completed										mpletion of ca death?	iuse
<u> </u>	The I	mo.							101	es 2 No	10	Yes 201	No
ta	iclan: The certificata rector, pag	Be	25. Wes case referred to medical					26. Plece of De	eth (Check only o	ne)			
2	Physician: this certific ral director,	10	exeminer? 1 ☐ Yes 2 ☐ No	Hospitel: 1 ☐ Inpatie	nt 2 🗆	ER/Outpetient	3□ DOA Ot	ner: 4 Nursing I	Home 5 Resid	lenca 6 □Oth	er (Specify	1)	
ם	fer th		27. Menner of Deeth 1. ☑ Naturel 5 ☐ Pending	28a. Dete of Injur (Month, Dep	Year)	28b. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe h	now injury occurr	red		
0	auth. Pr: Al	atic	2 Accident Investigation					Yes 2 □ No					
Š	i or Attending P saftar death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At ho	me, farm, stree	et, fectory, office		28f. Location (5 City or Tow	Street end Numb m, Stete)	er or Rurel	Route Numl	ber,
	is af	Cer											
	Mospital or Attending A hours after death. Funeral Director: After ietaly filled in by the fune	edicai	(Check only 2 Medical Example 12	ysicien: To the best onliner: On the basis of	f my knov examinet	wledge, deeth o	occurred et the ti	me, dete and place	e, end due to the durred et the time.	ceuse(s) end ma	nner es sta	ated. the ceuse(s)	
	To the Hospital or Attending Physician: The is within 24 buts after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	Med	one)	end menner ste									
	5 ± 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	29b. Signeture end title of cartifier				29c. Licen:	se number		29d. Dete signe	J (Month, E	Jey, Year)	C
			Janel	woher	1	D	D4	6118		April	24	199	8
	18		30. Neme end address of person who	completed cause of de	eth (Item	23e) (Type, P	rint)				•		
	1		Janet Cooper,	M.D. 1	447	York	Rd L	uthervi	lle, MI)			
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 4 1	32. Regis	Signa Da	ruje	indell						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Deeth Month **Physician** April Taylor 9:50 AM Raymond /Medical 4a. Fecility Nema (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince George's Hospita Laure aure! If Under 24 Hrs. 8. Dete of Birth (Month, Day. If Under 1 Yeer Months Deys 7. Aga (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) 5. Social Sacurity Number **Funeral** 1 M 2 F 3 216-10-5586A Usual Residence of Decedent Yrs. Director June 19, 1914 Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Madical Examiner must be notined at 1 ☐ Yes 2 No Director Anne Hrunder 10e. Street end Number 10f. Zip Cod 10o. Citizen of What Country? Avenue N.W 21060 Jac Funeral Was Decedant Ever in U.S. Armed Forces? 1 Kyes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Rece - Amarican Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 3altimore, Maryland 21215-0020 1□ Yes 2XNo Specify: à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Department of Agriculture tedera Government 18. Mothar's Nama (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middla, Last) Be 2 should be f and Mental I 2 permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other treum 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Running Deer Way, Bowie Maryland 20720
20c. Location City or Town Stata Darbara WILEU 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 Buriel 2 Cramation 3 Removel from Stete 4 Donetlon 5 Other (Specify) protoma 22. Name and Address of Fecility
Joseph H. Brown Jr. Fureral Home, PA.
240 N. Fulton Avenue Baltimore Maryland 417 21. Signeture of Funeral Service Licensee Kins) 2140 Vor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or hear failure. List only one cause on each the. Physician Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical weeks Reshiratory Examiner Due to (or es e consequenca of): Examiner weeks aspiralun physician and the burial-trensit Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. 3-4 weeks · Advancel chronic obstructive Physician/Medical Due to (or es a consequance of): disease Division of Vital Records, P.O. Pert II. Other eignificant conditions contributing to deeth but not rasulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 T Yes 2 No. Jeclin by 24b. Wara autopsy findings evelleble prior to completion of causa of deeth? 24a. Was an eutopsy Completed peen certificate hes 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Electrolyte imbalance 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To his funeral 28e. Dete of Injury (Month, Day Year) ve Hospital or Attanding Ph n 24 hours after death. ve Funeral Director: After th 27 Menner of Death 28d. Dascribe how Injury occurred 28c. Injury et Work? 1 MNeturel 5 Pending Investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide 29a, Certifier

To the To the To the F

completely

31. Date filed (Month, Day, Yeer) State

PADMAJA

(Check only one)

29b. Signeture end title of cartifier

APR 24 1998

llela

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

7350 Van Dusen Road SULTE 380 LAUREL SHRINIVAS UDAPI 32. Registrer's Signature

123 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to tha cause(s) end manner steted.

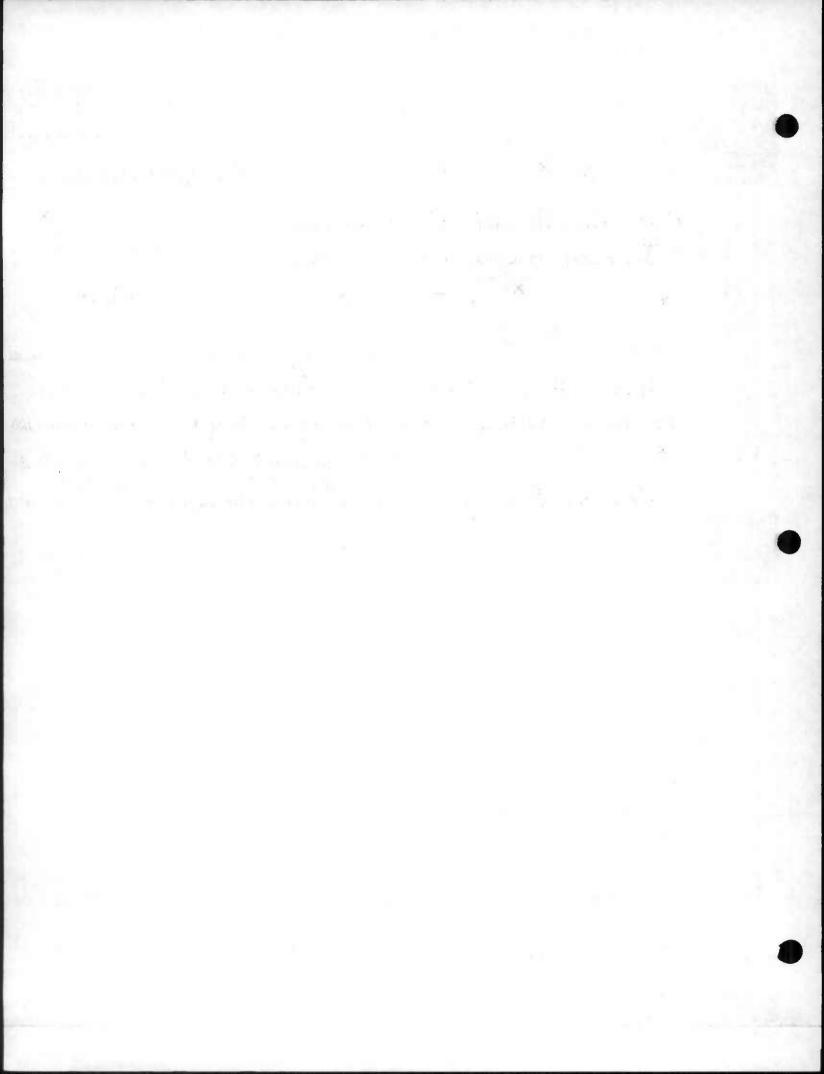
29c. Licensa number

D24174

29d. Data signad (Month, Dey, Year)

APRIL 23, 1998

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

GARY	A.	TYLER
ACD		

AS	P			State of Maryland /	Certificate of		Reg. No.	8 12953
	Physician	1	1. Decedent's Name (First, Middle, Last	Δ	Tules	44.7	2. Date of Death	3. Time of Death
	/Medica Examine	r	4a Fecility Name (If not institution, give MARYLAND SHOCK 7 5. Social Security Number 6. Se	TRAUMA	birthday) If Under 1 Yea		E N	9. Birthplace (State or Foreign
	Funeral Director			M 20F 50	Yrs. Months Day	s Hours Min.	May 25, 1947	Maryland
	deeth with the Menyland rms 23a or 28a-f show rms to notified at		10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits Yes 2 □ No
	ifier deeth with the Mei r ferma 23a or 28a-f si choet must be not fred	פנמו סוב	588 Baker	Street	10f. Zip Code	1217	10g. Citizen of	S A.
0050	urs after	2	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 No If Yes, Give 9-10-66 Yeer or Dates - 11-69	13. Was Decedent of If Yes, specify Cu	lo Specify:	Specify	ck, White, etc.
21215-0020		Completed	15. Decedent's Edu (Specify only highest grad	cation 10 completed) College (1-4or 5+)	6a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	1 1 14	16b. Kind of B	of Baltimor
Maryland	Mental H arked oth	o pe o	17. Fether's Name (First, Middle, Last) Albert L.	Robinson		Paul	ne (First, Middle, Maiden Suman	r
altimore, Mar	00-		19a. Informent's Name/Relationship (T) Nevin Tyer 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Cbrother) 20b. Place came	9b. Mailing Address (Street Street hton		, State, Zip Code) OFR Muryland 2121. - City or Town, State	
Baltir	permit. Peg Department Important: I any injury o		21. Signeture of Funerel Service Licens 23a. Pent1. Enter the disease, or compleshock, or heart failure. List only or		22. Name and Add Joseph 2140 N.	H. Brown	Tr. Fureral Ho erue, Baltimore	me, PA. Maryland a1215
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complished. List only of shock, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in death)	ications that cause the death. In the cause on each the.			c or respiratory arrest,	Approximete Intervel Between Onset and Death
	N 100	5	resoning in death)	Due to (or as	a consequence of):			
90,	urial laneit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenca of):			
Box 68760,	certifi ding se es	6	that initiated events resulting in death) Last	Due to (or as	a consequenca of):			
P.0.	d by the deteched		Part II. Other significant conditions cor	tributing to death but not resulting	g in the underlying cause	given In Part I.	23b. Did tobacco use co 1 ☐ Yes 2 ☑ No	ontribute to the cause of death? 3 Probably 4 Unknown
Records,	s been sign	וחופופת מ					24e. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
	certificate he		OF Management and the state of				1 No Yes 2 No	1 No 2 No
Vita	Physician: this certificated director,	ם ו	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospital: 1X Inpatient 2 ☐ ER/	Outpatient 3 DOA	Othor	ath <i>(Check only one)</i> Home 5 □ Residenca 6 □Oth	her (Specify)
on of			27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	The second secon	b. Time of 28c. In Injury		28d. Describe how injury occur Subject St	rred
Division	b Hospital or Attending Ph 24 hours after death. Funeral Director: After th etely filled in by the funeral		3 Suicide 6 Could not be determined	28e. Placa of Injury - At home building, etc. (Specify)	, farm, street, factory, offic	DB	28f. Location (Street and Num. City or Town, Stete) 588 DAWNST 1.	
	Hospital 24 hours a Funeral Dietely filled	100	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred et the end/or Investigation, In m	time, dete end plece y opinion, deeth occu	e, end due to the cause(s) end m urred at the time, date end place,	enner es steted. , end due to the ceuse(s)

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) D. Koptu um MAND Q (37)
31. Date filed (Month, Day, Yeer)
APR 24 1998

29b. Signature and title of certifier

111 Penn Street, Baltimore, Maryland 21201

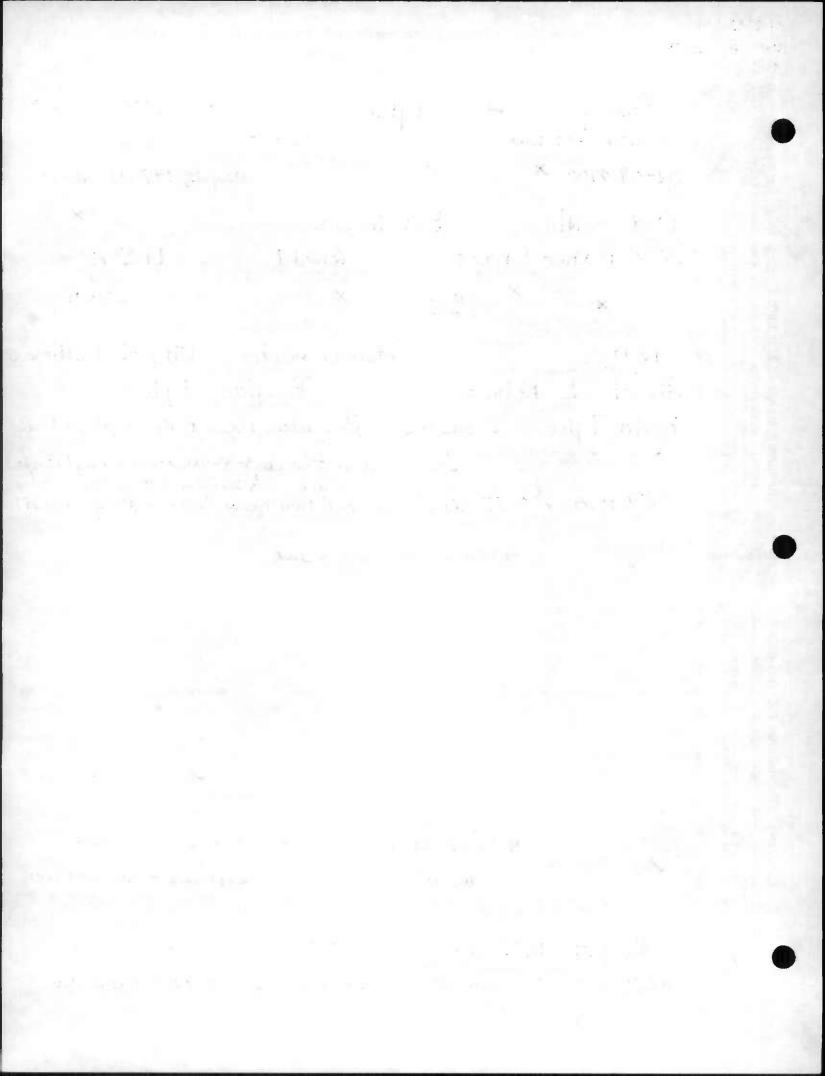
29d. Date signed (Month, Day, Year)

APRIL 23,1998

29c. License number

O.C.M.E

State Registrar 22 Augistrar's Signature his Pavidson-Mondalls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** FRANCE WILLIAMS 522 PM APRIL 20 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL BALTO N/A If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
OCT 26, 1 If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 □ M 2√2 F 66 228-50-4241 Yrs. Director VA Usuel Rasidance of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland need of Health and Mental Hyglene.

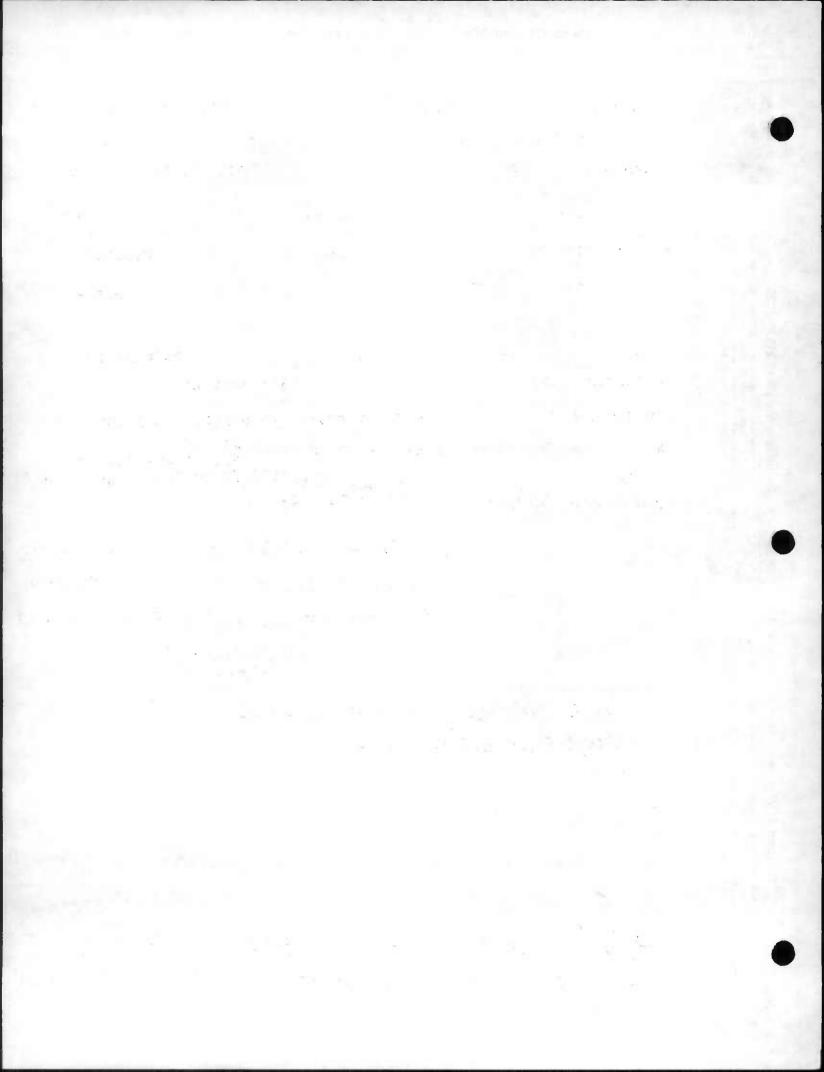
and: If Item 27 is marked other than "naturel", or items 23s or 28s-f ahow uny or other transmit be notified a 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Nas 2□ No MD N/A Directo BALTO 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5926 ST REGIS RD 21206 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas XX No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondery (0-12) Collega (1-4or 5+) 18. Mothar's Name (First, Middla, Maidan Sumama) 0 PACKER N/A 17. Fathar's Nama (First, Middla, Last) CLAYBORNE VENEY MARY SORRELL 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) PAULINE VENEY 5926 ST REGIS RD BALTO., MD 21206 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of 20a. Method of Disposition cematery, cramatory or other place)
MULBERRY BAPT CH YARD APRIL Department of Important: If It any Injury or c Buriai 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1998 EMMERTON, VA 22. Name and Addrass of Facility BETTS FH 0 1129 N BALOT, MD 21213 BARRY 0 WADDY 21. Signature of Funarai Sarvice Licensee CAROLINE ST 23a. l art1. Entar tha diseasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. alucea LANCASTER, Approximata intarval Batwaan Onsat and Death Physician Immediata Causa (Final disaasa or condition resulting in deeth) /Medical **Examiner** Examiner The law requires that the death certificate becomed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last HemoTHORAX intraoperative P.O. Box 68760. Physician/Medical Dua to (or as a consequa ACE MENT OF JUGULAR DIALYSIS CATHETER Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy parformed? Completed completion of cause of death? director, page 2 s 1 Yas 2€ No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was cesa rafarred to medicel axaminar?
1 ☑ Yes 2 ☐ No Be 26. Pleca of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Data of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mennar of Death 28b. Time of Certification: After 5 Pending Invastigation 1 Netural e Funeral Director: Afti Jetaly filled in by the fur 1 Yes 2 No 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Sulcida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida edical 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. Licansa number

State Registrat

31. Data filad (Month, Day, Yaar)

30. Nama and addrass of parson who completed ceuse of daam (Itam 23a) (Type, Print)

DRIVE SWITE A 4820 SETON 32. Registar, Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** WILLIAMS 1:10A INTHONY toril /Medical 4a Fecility Neme (If not Institution, give street and number) 4b_City, Town, or Location of Deeth 4c. County of Death Examiner Hos saltimore PKins Ho Johns 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplece (State or Foreign Gountry) 5. Sociel Security Number **Funeral** 214_68-370
Usual Residence of Decedent 1 M 2□F Maryland Months Days Hours Yrs. Director the Maryland 10b. County, 10c. City, Town of Location 10a. Stete 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f shor traumetic event, the Medical Examinar must be nouthed at 1 Pres 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it begarment of Health and Menial Hygiena. Important: if item 27 is marked other than "not page. 2820 21216 Funeral Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. 11. Meritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Erican 1 ☐ Yes 2 1 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decadent's Education (Specify only highest grede comp 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use refired) Cotlege (1-4or 5+) Elementary/Secondary (0-12) rounds Keepe 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether Neme (First, Middle, Last) CUEINA Hlexande hono (SISTER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number of Rural Route Number, City or Town, Stete, Zip Code) unlhia 20b. Place cemet 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Þ we Baltimore 21216 Willorthe se, or completitions that caused the death. Do not . List only one cause on each line. Approximete Intervel Between Onset and Deeth Part1. Emerthe disease shock, or heart failure. **Physician** /Medical Immediate Cause (Finet PNEUMONIA TWO WEEKS diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner FTROVIRAL INFECTION UNKNOWN Prans Sequentielty list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MENNGITIS signed b RYPTOCOCCAL by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed DISSEMINATED MYCOBACTERIUM AVIUM COMPLEX ESOPHAGITIS 2 No ANDIDA 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident efter death Director: 6 Coutd not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 Homicide 24 hours efter Funeral Dire letely filled in b Hospital 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steted. Medical completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pteca, end due to the ceuse(s) end menner stated. (Check only one) To the Vithin 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M'Comul MD 21, 1998 RES-000

JOHNS HOPKINS HOSPITAL BALTIMONE MARYLAND

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

TOWER 110

who Davidson

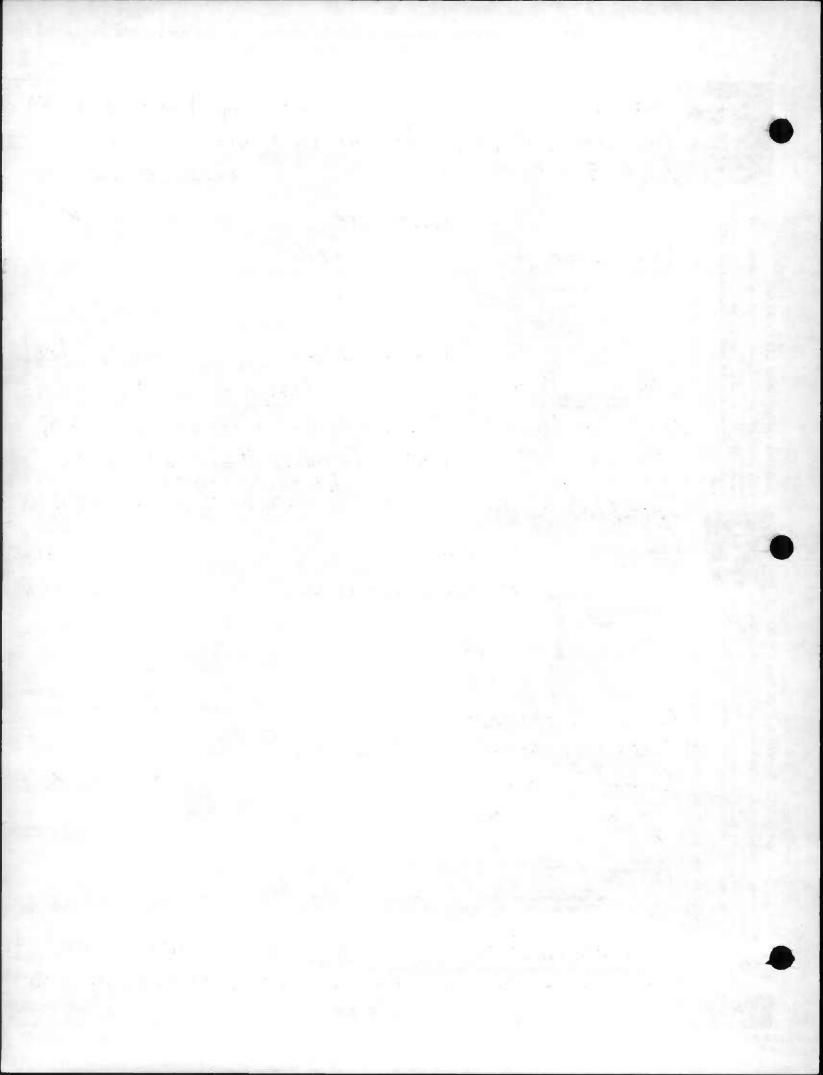
RALHEL MCCORMICK

APR

31. Date filed (Month, Day, Yeer)

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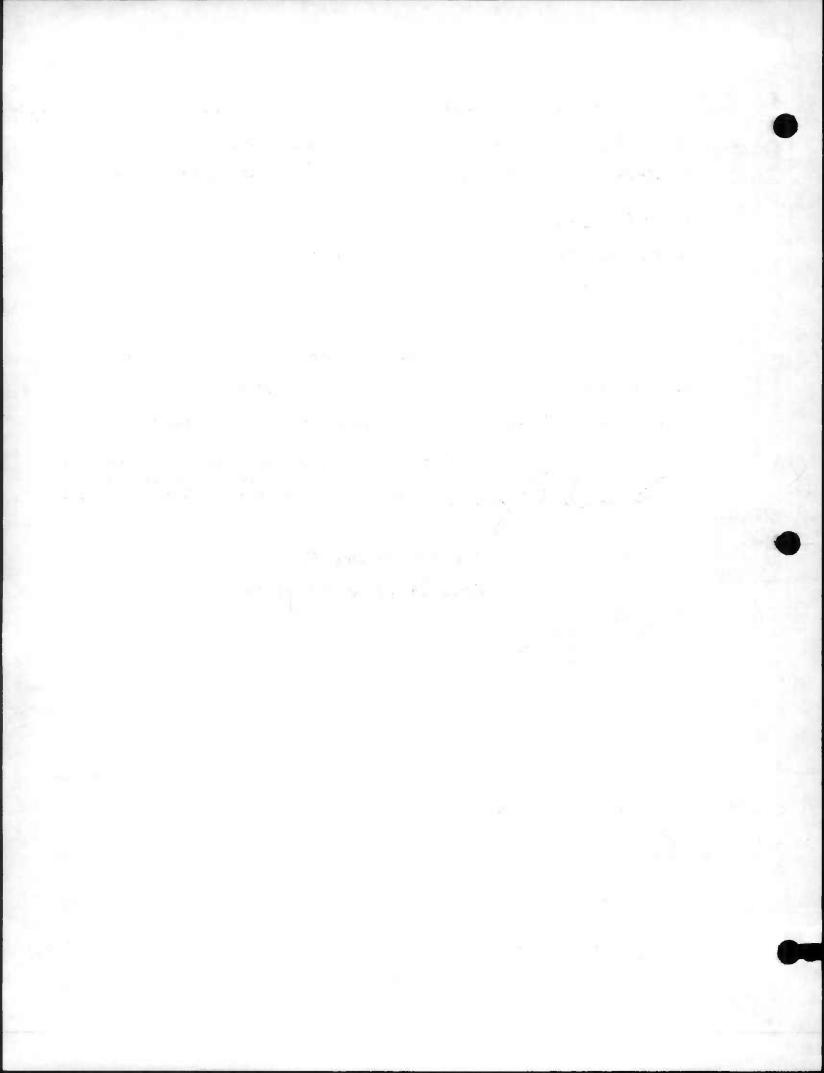
State



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10		Items:10c,d per F.H G. 1. Decedent's Name (First, Middle, Las		Cert	rificate of	Death	2. Date of De	Reg. No.	3. Time of Death
Physici /Medic Examir	cal	ANNIE 4a. Facility Name (If not institution, give	E. WH	ITAK	ER	4b. City, Town, or BACTIN	Month APRI Location of Deat	L 19TH	Yeer 1998 4-08
Funeral Director		5. Social Sacurity Number 6. S		last birthday) Yrs.	If Under 1 Year Months Days		s. 8. Date of Bi	ay, Year)	9. Birthplace (State or Fore Country) North Carolin
a-f show find at	tor	Maryland Baltimo	Do	y, Town or Loc 1timor		AWN			10d. Insida City Limi
from 23e or 28e-f show from must be notified at	al Director	10e. Street and Number 3402 Rockdale Cou			10f. Zip Code 212	44		10g. Citizen of V	
naturel', or items 23e or 28s-f show	by Funeral	11. Marital Status 1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Under Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	if	as Decedent of I	Hispanic Origin? (an, Mexican, Pue	Specify Yas or Norto Rican, etc.)	14. Rac Blac	ee - American Indian, ck, White, etc. Y: Black
than the Me	Completed	15. Decadent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give k life. D	int's Usual Occup ind of work done O NOT use retire	during most of world)	orking		usiness/Industry
d other	To Be Co	17. Fether's Name (First, Middle, Last) Charlie Staton				18. Mother's Na			ne)
Health ar		19e. Informent's Name/Relationship (7 Lethella Campbell 20a. Method of Disposition	/Daughter	4229 I	Fallstaf			Maryla	nd 21215 City or Town, State
Depertment of I Important: If Ite sny injury or o'		1 Burial 2 Cramation 3 4 Donation 5 Other (Specify	Garr	ison Fo	Name and Addre	metery O	errick (C. Jones	Mills, Md. Funeral Home Md. 21215
nysician		23a. Part1. Enter the disease, or compshock, or heert failure. List only	olications trin caused the death						Approximate Interval Between Onset and Death
Medical xaminer transit the private transit to the private transit tra	edical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b. Due to (o	r as a consequence as a	ence of):	mylo	DM 9 /		
y the ettending packed for use as	Physician/M	Part II. Other eignificant conditions on	d	ulting in the und	derlying causa gl	van In Part I.	23b. Did	tobacco uae co	ntribute to the cause of deat
been signed by the e should be deteched	by						24a. Was	Yes 2 No s an autopsy ormed?	3 Probably 4 Unknot
ata hes	Completed						10	Yes 2010	completion of cause of death?
ter this neral di	ation: To Be	25. Was casa referred to madical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: Impatient 2 28e. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing	Home 5 Res 28d. Describe		
us after death. ral Director: Af lied in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	et, factory, office			(Street and Numb wn, State)	ber or Rural Route Number,
within 24 hours after To the Funeral Direcompletely filled in b	Medical	(Check only 2 Medical Exam	relclan: To the best of my kno- iner: On the basis of examine and mannar stated.	wledge, deeth o tion and/or inve	stigation, In my	opinion, death occ	ea, and due to the curred at the tima,	date and place,	and due to the cause(s)
To I	N	29b. Signature and title of certificity 30. Name and address of person who	Ibazel	23a) /Time P	29c. Licen		0		16 (Month, Day, Year) 16 197#199 2120)
1		821 No 1	-4.TAW) S	1 23e) (Type, P	407	BOAT T	MORE	MS	21222

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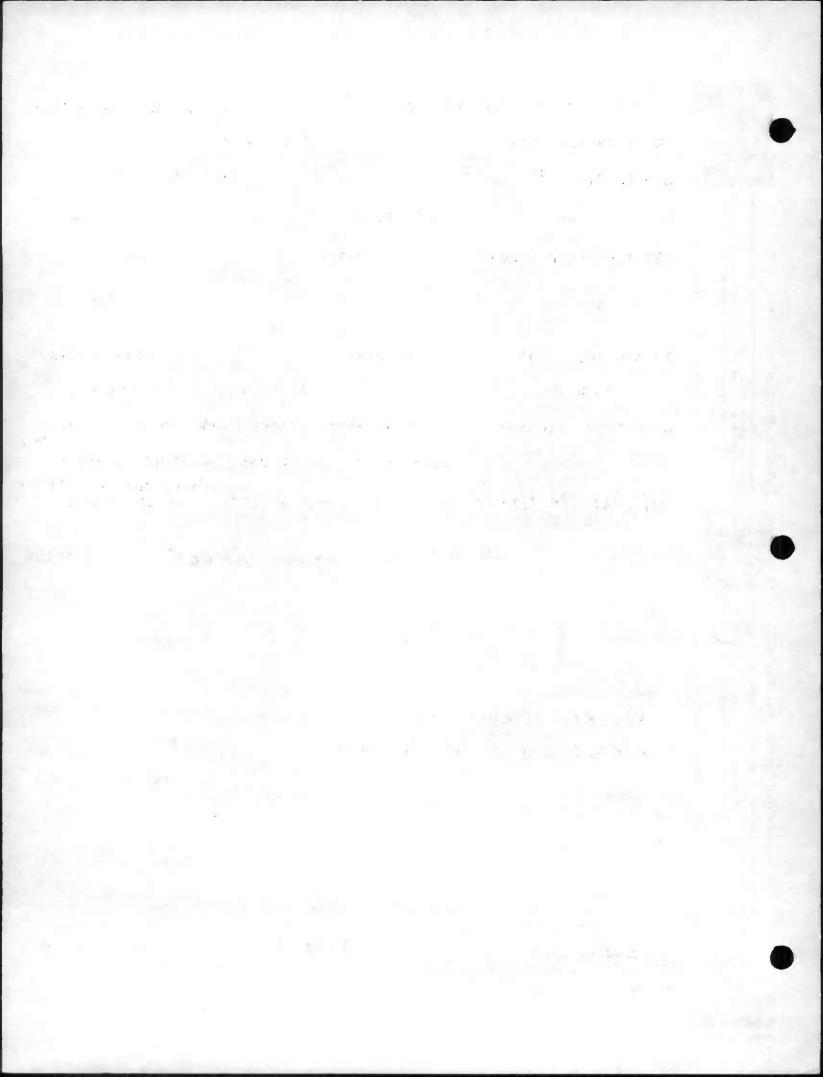
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** William Ambrose Wilson 20, 98 April 4:30am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner 429 Ilchester Avenue Baltimore If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Deys XXM 2□F 72 Yrs MD 07-19-25 **Director** 220-12-8425 with the Maryland 10a. Stete 10c. City, Town or Location 10d. Ineide City Limits r 28a-f show 10b. County Md Baltimore 1 X Yes 2 □ No NA Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number "natural", or itema 23a or edical Exercises rount be USA permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a and Injury or other traumatic event, the Medical Examiner man and page. 429 Ilchester 21218 Avenue Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 10th Grade Laborer various trades 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Fidella Unknown Boone 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) 14693 Rasom Street Woodbridge, VA. 22191 Gwendolyn Jackson 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) Garrison Forest VA Cem. 04-24-98 Owings Mills, 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical LUNG CANCER MERASTATIC 9 YEARS Examiner Physician/Medical Examiner Sequentially list conditions, it eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SEVERE CARDIOMYOPATHY by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed CEREBROUASCULAR DISFASE certificate has t 1 ☐ Yes 2 No 1 ☐ Yes No Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home Residence 8 Other (Specify) 10 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Dey Year) After t or Attending 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No r death. after death.

I Director: A
od in by the fu investigation 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Director completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the Frithin 2 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 041637 APRIL 22,1998 30. Name and edd of person who completed cause of death (Item 23e) (Type, Print) SALIM 3333 N. CALVERT 50 -BACHMORE 31. Dete filed (Month, Day, Year) APR 2 4 1998 32. Registre whice Davidson-Randolle.

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	Funeral		5. Social Security Number	6. Sex	M 00 F	-	(In yrs. last		If Unde Months	r 1 Yaar Deys	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	rth ey, Year)		9. Birthple Counti	oce (St	teta or Foraign
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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Dey 1998 **Physician** April 17, James Delano Williamson, Sr. 4:20 A.M. /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 9. Birthplace (State or Foreign Country)
Tennessee 7. Age (In yrs. last birthday) **Funeral** Days 1 XX 2□ F 411-54-3867 Yrs. Director Usual Residence of Decedent death with the Meryland 10b. County 10c. City, Town or Location 10d. inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Meryle nent of Health and Mental Hygiene.
If I flem 27 is marked other than "natural", or Itema 23a or 28a-f shown into or other traumatic event, it was east Example man to nother traumatic event, it was east Example man to nother traumatic event. 1 No 2 No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12809 Belhurst Lane 20715 United States by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1 XYas 2 No Yes If Yes, Give Yaer or Dates: Korea Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: NO 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Williams A. Williamson Mary Earl Laxton 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Williamson/Wife Bowie, MD 12809 Belhurst Lane 20b. Plece of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Femation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Northern Virginia Crematory4/19 Arlington, Virginia 21. Signature of Funeral Service Licensaa 22. Name and Addrass of Facility Robert E. Evans Funeral Home, Inc. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, only one cause on each line. Approximata Intarval Between Onset end Death **Physician** archenowith Pulmonany a /Medical Immediate Cause (Finel ~2 Months disaasa or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consaquana) P.O. Box 68760, Yol Physician/Medicai Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse givan in Part I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown page 2 should be de Records, þ Completed 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes an autopsy performed? certificate 1 ☐ Yes 200No Division of Vital Hospital or Attending Physician: director, Be 25. Was cese referred to medical axaminer? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? After 1 ANaturel 5 Pending s efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) menner stated. Medical 29e, Certifier completely ro the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Impleted cause of deeth (Item 23e) (Type, Frint),
TZEN \$ 926 WCC) YOUR

State Registrar 31. Dete filed (Month, Day, Year)

ADR 9 4 1008

32. Megistar's Signeture Fund



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Lest) A Month 2. Date of Death Dennis A. Wample 0221 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 XM 2□ F Yrs. 222-28-6600 DEC 8, 1946 Delaware Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Cecil North East 1 ☐ Yes X☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 949 Shady Beach Road 21901 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 X Married 1 ☐ Yes ¾☐ No Specify: White Specify: 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 12 Electrician Union 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Irvin M. Wample Bertha Rodgers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Virginia Wample/wife 949 Shady Beach Rd. North East, MD 21901 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Other (Specify) Metro Crematory, Inc. 04/23/98 Baltimore, MD 21. Signeture of Funeral Saruce Licensee 22. Neme end Address of Fecility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 C Dawn F McDonald 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other algnificant conditione contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

Physician

/Medical

Examiner

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Funeral

by

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5 23a

"natural", or items

other traumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetin

Baltimore, Maryland 21215-0020

Box 68760

Examiner Medical Certification: To 報 Altec death. Director or A

Physician/Medicai py Completed Be

25. Wes case referred to medical exeminer? 27. Manner of Deeth

3 Suicide 4 I Homicide 29a. Certifier

1 Neturel

2 Accident

1 ☐ Yes 2 No

5 Pending Investigation 6 Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of

Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

26. Plece of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end placa, and due to the ceuse(s) end manner es steted.

Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29b. Signeture endatitle of certifier

29c. License number

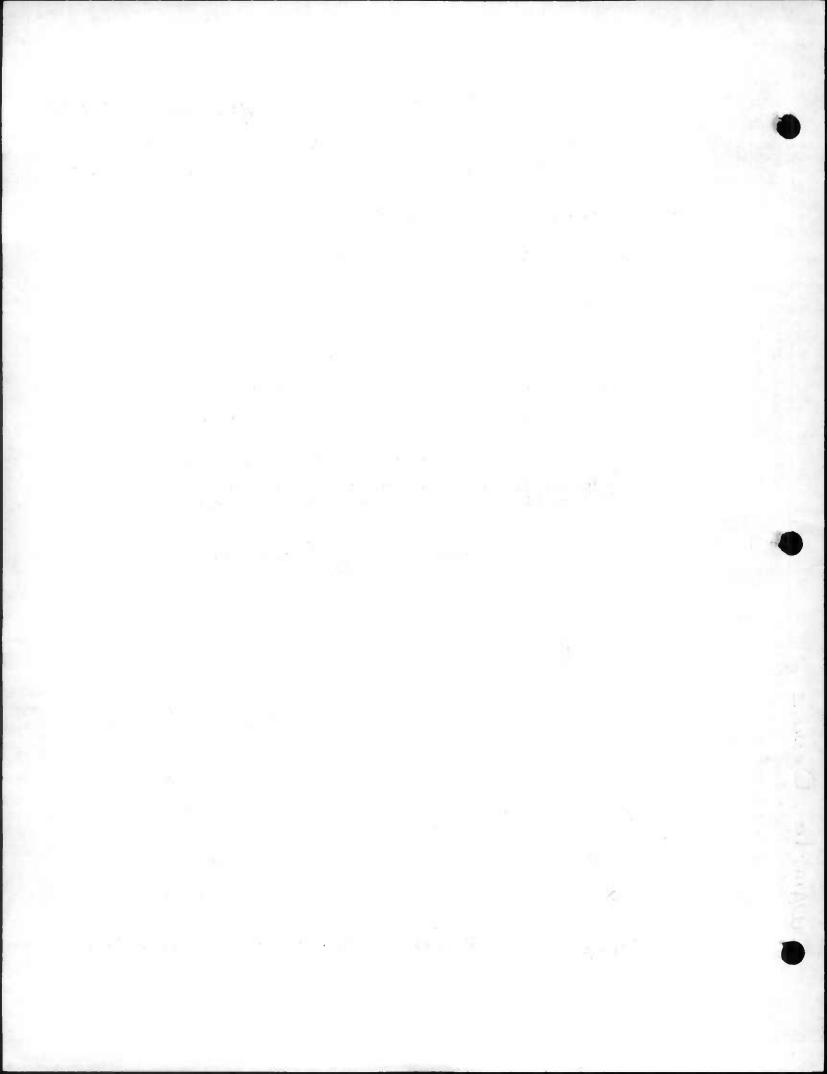
29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

PATE 1700 SHAILCROSS RYZ WIMINGTON DE 32. Registre la gone de de la granda de la gr 1998

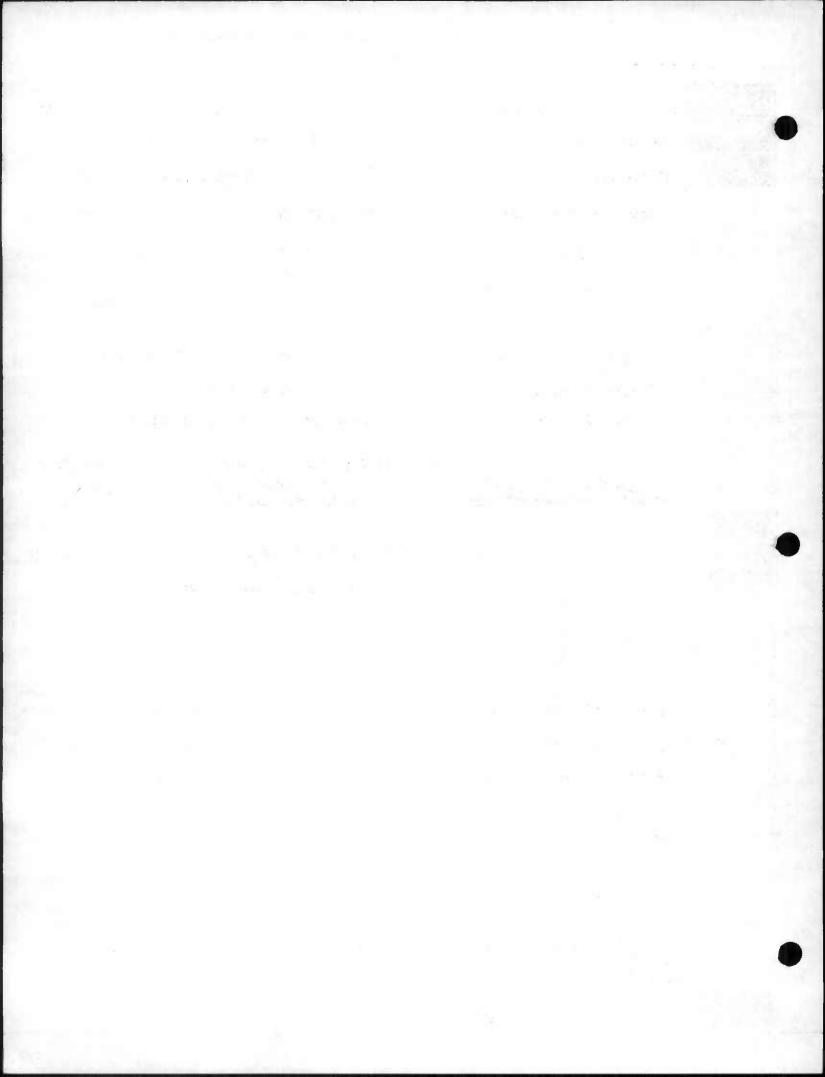
State Registrar

To the Hospital within 24 hours a To the Funeral D



State of Maryland / Department of Health and Mental Hygiene

Ame	nd: #8 Pe	r F	H Film G758 4-28-98RC			Certificate of	Death		Reg. No.	1 1.44	
			1. Decedent's Neme (First, Middle, Las	t)				2. Dete of De	eeth	Wester	3. Time of Death
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	pue *		Usual Residence of Decedent 10a. Stete 10b. County		10c. City. To	wn or Location	-	MARCH		10	0d. Inside City Limits
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	ath with the 23a or 2	rai Dire	10e. Street end Number 6011 Plumer Avenu	le		10f. Zip Code	21206		10g. Citizen of V USA	Vhet Count	try?
Maryland 21215-0020	filed within 72 hours after death with the Marylend Hygiene. "natural", or fterns 23a or 28a-f show ther then "natural", or fterns 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Meritel Status 1 □ Never Merried ※ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent En Armed Forces? 1 Yes 22 Not If Yes, Give Yeer or Dates:		13. Was Decedent of If Yes, specify Cul		ecify Yes or No Rican, etc.)		e - America ck, White, e Whit	etc.
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yla	Mentel Merked of	P	Charles A. Sch					a Malku			
Jar	C1 0 9 6		19a. Informent's Name/Reletionship (7			9b. Meiling Address <i>(Stree</i> 6011 Plumer					Code)
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	N	Mrs. Tracy L.	Zio	nczkowsł	ci/wife	4108	Kenan	Ct.	Wilm	inato	n. N.	C. 2840	3	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 07:48 PM **Physician** 1998 RONALD AUSTIN APRIL /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CLINTON SOUTHERN MARYLAND HOSPITAL CENTER PKINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) **Funeral** Days 1 MM 2□ F Months Hours 122-24-8429 64 Director May 2,1933 New York State Usuel Residence of Decedent the Maryland 10d Inside City Limits 10a State 10h County 10c, City, Town or Location 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, if a Medical Executive must be notified at 1 ☐ Yes 2√2 No Director Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street end Numbe 10f. Zip Code 9302 Fairhaven Avenue 20772 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. If it is the state of the Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11 Marital Status Black, White, etc. 1 Never Merried 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Aq 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S.A.F. Ret. Full Col/06 +7 U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Austin Mildred Blaum 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa Austin (Daughter) 9302 Fairhaven Avenue Upper Marlboro, MD 20772 20b. Place of Disposition (Neme of cametery, crematory or other placa) April 17, 20c. Location - City or Town, State 20a. Method of Disposition Name 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Resurrection Cemetery 1998 Clinton, Maryland 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 Part 1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequenca of): Box 68760, Physician/Medical Due to (or as a consequenca of) signed by the aid be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the causs of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen s page 2 has 1 ☐ Yes 2 No 1 Yes certificate I or Attanding Physician: after death. Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ← ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2□ No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral Di completaly filled I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signaturerand title of certifier D33954 APRIL 13, 1998 DME

3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

State Registrar 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

1998 ▶

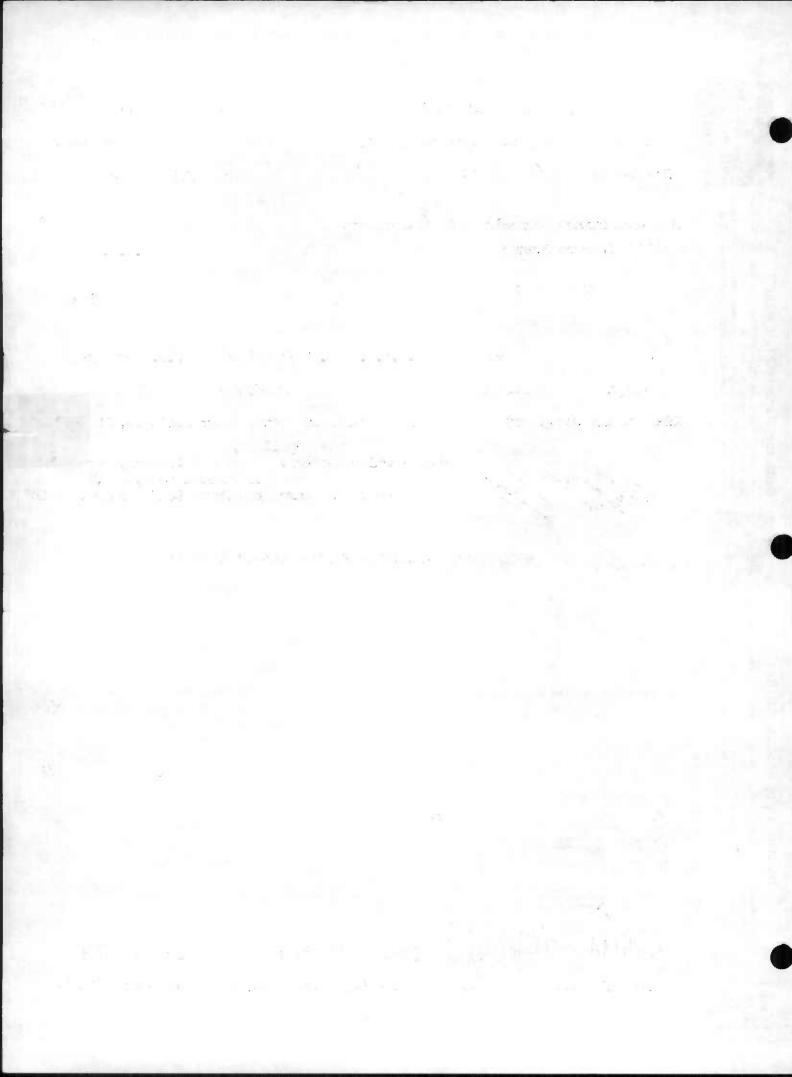
32. Registrate Signature

8 Juli Shudsen Randall

MARIO F. GOLLE

APR 1

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month John Woodman Bryan Barlow APRIL 08, 1998 5:05 A.M. 4a. Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthpiece (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 10XM 2□ F Months Deys 579-38-3700 69 Yrs June 21,1928 Washington DC Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Prince George's Camp Springs 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20748 U.S.A. 5403 Ludlow Drive 12. Was Dacedent Ever in U.S. Armed Forcas? 1949— 1 (2) Yes 2 □ No If Yes, Giva Yaar or Detes: 1977 Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, Whita, atc. 1 Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No White 3 Widowed 4 Divorced Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Lt. Col. U.S. Air Force Ret. U.S. Government 5+17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Bryan Helen Barlow Raymon 19e. Informent's Neme/Reiatlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lolete F. Barlow (Wife) P.O. Box 754 North Beach, Maryland 20714 20b. Plece of Disposition (Name of cemetery, cramatory or other place) April 10 etc. 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramovel from State 1998 4 ☐ Donetion 5 ☐ Other (Specify) Arlington, Virginia Arlington National Cemetery 21. Signature of Funerei Service Conse 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Pertr. Enter the disease, or complications that shock, or heart fallure. List only one cause of not enter the mode of dying, such as cardiac or respiratory arrast, Approximate ntarval Between Onset end Death Immediate Cause (Final PANCREATIC ADENOCARCINOMA disaasa or condition resulting in deeth) 4 MONTHS Due to (or es e consequence of) Due to (or es a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en autopsy performed?

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

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Physician

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Examiner

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Director

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Baltimore, Maryland

Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events rasulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24b. Were autopsy findings available prior to completion of ceuse of deeth? NT / 7 N/A 1 ☐ Yes 2 ♥ No 1 Tyes 2 No. 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ▼ No 1 X Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 8 Could not be determined 3 Sulcide 28a. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

physician and the buriel-transit The lew requires that the death certificete be executed Box 68760 as P.O. bengis be del Records. page 2 s Division of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica 2 To the Hospital of within 24 hours a To the Funeral D completely filled I

1 McCertifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner ea atated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and menner steted. 29e. Certifier 29c. License number

29b. Signeture end title of certifier

29d. Dete signed (Month, Day, Year)

Donug 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 WEST PERIMETER ROAD

MD-057546-L

APRIL 08, 1998

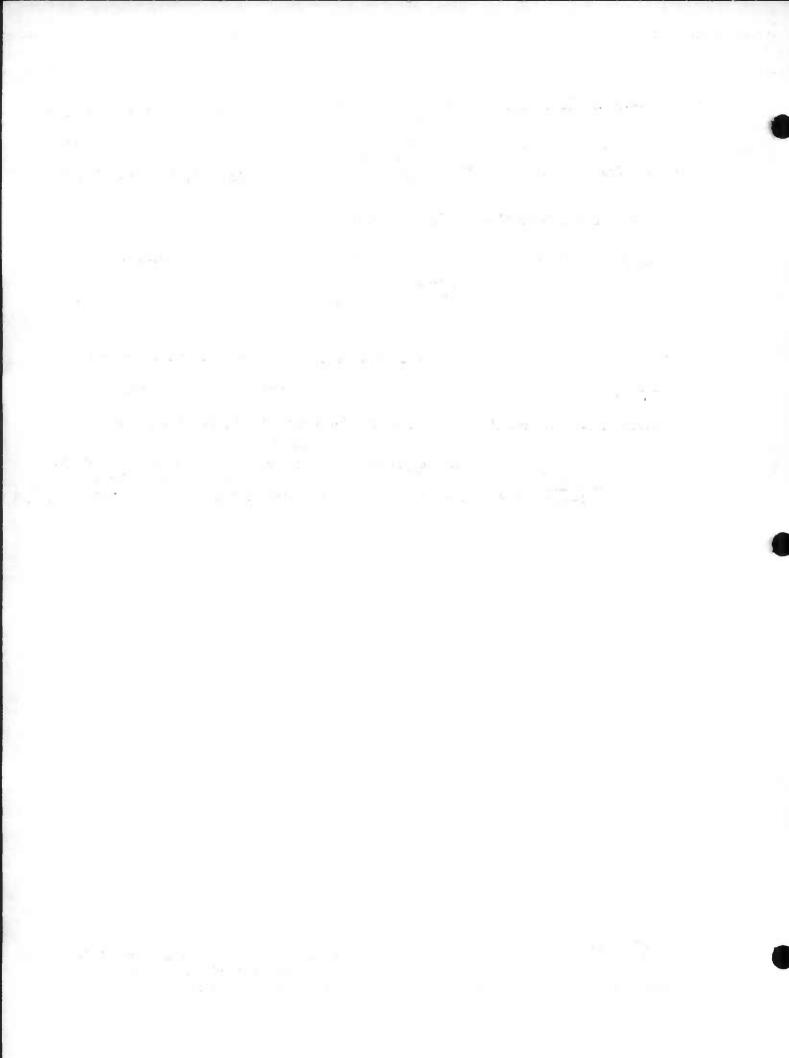
ROBERT B. DONEGAN, MAJ, USAF, MC 31. Dete filed (Month, Day, Year)

ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

32. Registrate Signature

8. Julia dhumber-Randall APR 1 5 1998 >



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey **Physician** Mary Frances Coates APRIL 8 1998 8:58pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner I A PI ATA I I Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 23, 1925 CIVISTA MEDICAL CENTER CHARLES If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) 1 M 2 KF Months Deys 577-32-3728 Pennsylvanian 72 Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Charles Nanjemoy 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 11260 Maryland Point Rd. 20662 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Detes: 11. Maritel Status Wes Decedent of Hispenic OrlgIn? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2√2 No Specify: Completed by Specify: Black 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Hospital Nurses Assistant 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be John Henry Ross Mary Agnes Newman 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Vivian T. Coates Daughter 3287 Ryon Court, Waldorf, Maryland 20601 20b. Place of Disposition (Name of cometery, cremetory or other place) Pril 14, 149998 20c. Location - City or Town, State 20a. Mathod of Disposition 1 XBuriai 2 ☐ Cremetion 3 ☐ Removel from State Nanjemoy, Maryland Oak Grove Baptist Church 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service ! M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 e, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, List only one cause or a sch line. Approximete Intervel Batween Onset and Death Immediete Ceuse (Finel disease or condition rasulting in death) probably secondary from Jaspiration . Keepingtory grest Due to (or es e consequance of): Examiner Over as they dislace Due to (or as e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Lest failure Endstage renal Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown by 24b. Were eutopsy findings eveilabla prior to complation of cause of death? 24e. Wes an eutopsy performed? Completed 1 Yes 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No tp⊠Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b Time of 28d. Describe how injury occurred

Physician /Medical Examiner

important: if item 27 any injury or other to

Department

Funeral

Director

the Maryland

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77 la merked other than "netural", or terms 23s or 28s-f show traumstic event, the Medical Exertise man be notified at

Pagas 1 and 2 should be nant of Haaith and Mantel

buriel-transit physician s tha burie 88 been signed be should be date pege 2 funaral director, after death.

that the death certificate be executed

The lew requires

or Attanding Physician:

Box 68760.

P.O.

Division of Vital Records.

28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 5 Pending investigation 1 Matural 1 Tyes 2 No 2 Accidant 3 Suicide Could not be determined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida

29a. Certifiar (Check only one) Certifying Physician: To the bast of my knowledga, death occurred et the time, dete end piece, end due to the ceusa(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the tima, data end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier

29c. License number Physician

D45737

29d. Date signed (Month, Dey, Yeer)

30. Name end eddrass of person who complated causa of death (Item 23e) (Type, Print)

NIRMALADEVI GURUSAMY M.D. 6 POST OFFICE ROAD WALDORF MARYLAND 20602

State Registrar

filled in by

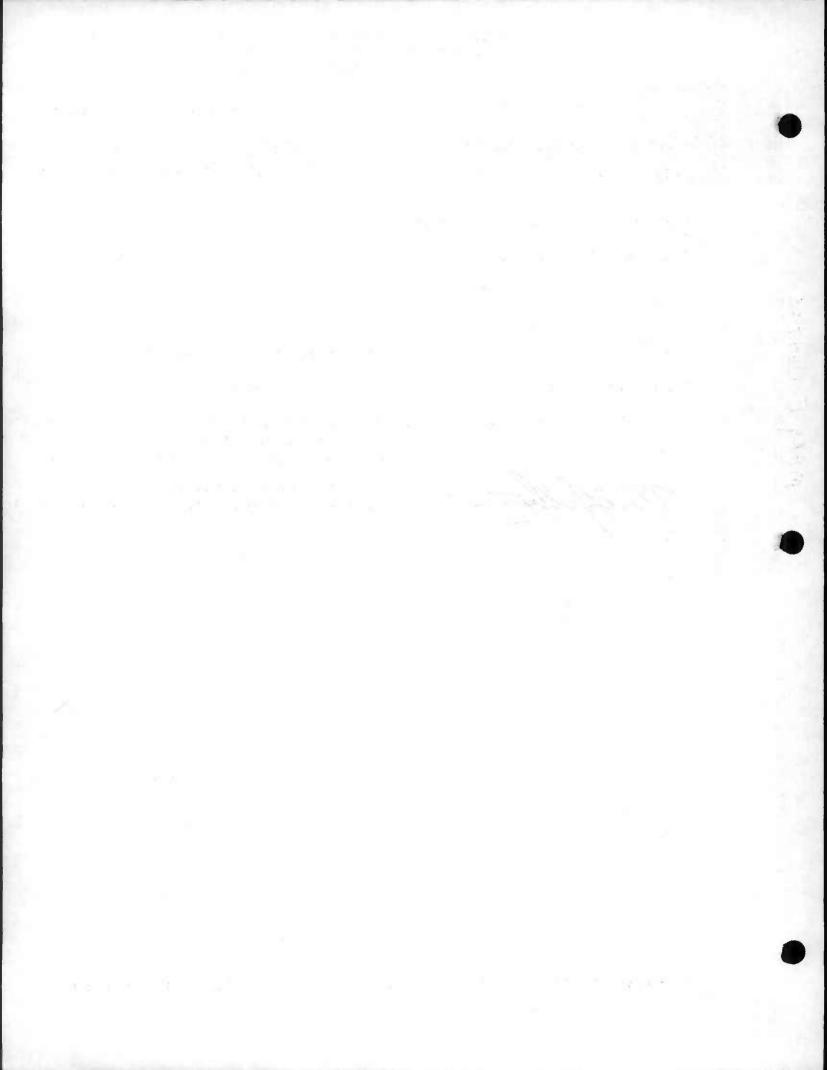
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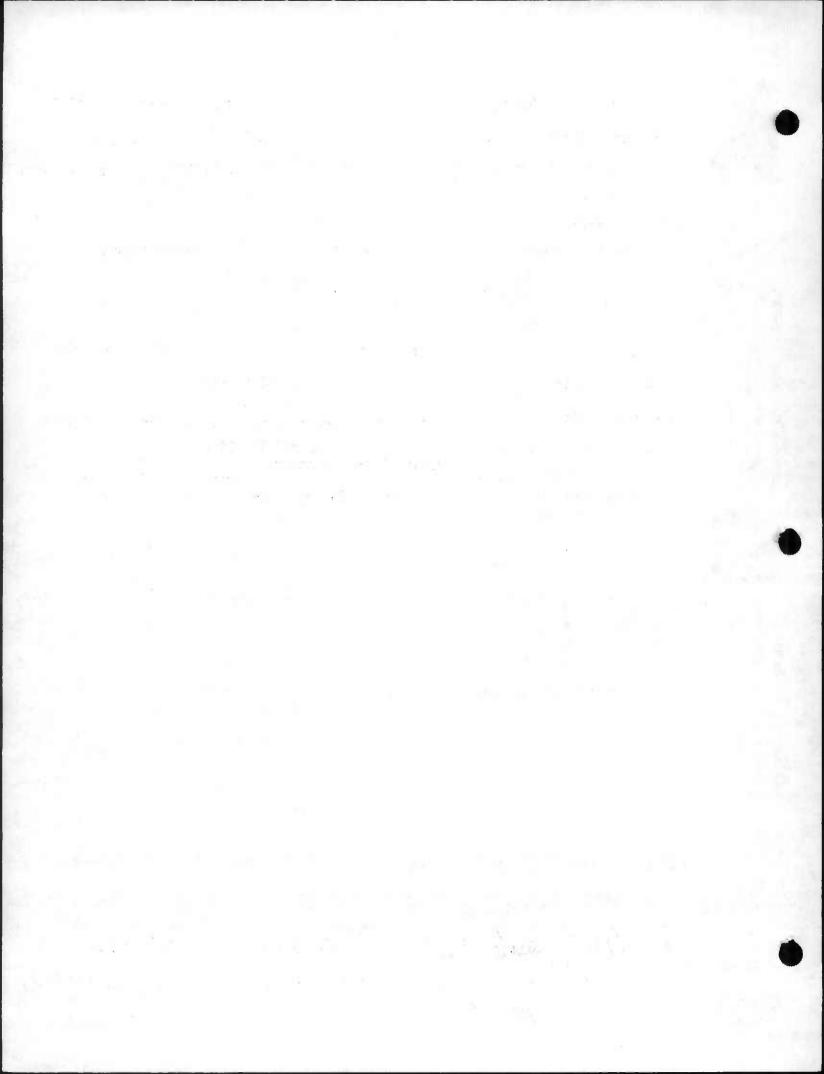
within 2

32. Registra 's Signature 31. Dete filed (Month, Day, Year) Julia Daviles Raylatt



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_				Cei	tificate o	f Death		Reg. No.		2966
Physici	an	1. Decedent's Name (First, Midd						2. Date of De		Yeer	3. Time of Death
/Medic	_	-	S. Durity					-	13, ^{Da} 1998		9:05 AM
Examir	er	4a. Facility Name (If not institution Crofton Con					4b. City, Town, or Crofton			of Death Arun	del
Funeral Director		5. Social Security Number 213 24 3809	6. Sex 1□ M 2/□ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bi	th 1 ^Y 91 ¹ 7	9. Birthp Cour Uppe:	place (State or Foreign Marlboro
3_		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Insida City Limits
of sho	0	MD P.G.				ct Heigh	ts				1 ☐ Yes 2 XX No
a or 28a-f show	Director	10e. Street and Number			DISCIL	10f. Zip Coda			10g. Citizen of	What Cour	
23a o	al D	6406 Halleck	Street			20747		1	United S	State	S
natural", or items 23a or 28a-f show	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☒️ vorced	12. Was Deced Armed For- ied 1 Yes 1 If Yes, Give Yeer or De	es?		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 N	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Ricen, etc.)	14. Rac Ble Specify	ce - Americ ck, White, y: Wh	
"natural",	eted	15. Deceder (Specify only highe	t's Educetion		16a. Deced	lant's Usuai Occ	upation e during most of wor ed)	rkina	16b. Kind of B	usiness/in	dustry
2.53	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)			ed)	All g	Board (of Ed	ucation
the bearing	ပိ	17. Father's Name (First, Middle,	(net)		pecre	etary	18. Mother's Nar	na /Finak klininia			ucacion
f Health end Mental Hy tem 27 is merked our other traumatic even	Be c	Plummer E. Sm						izabeth.		ne)	
end Mental is marked or aumetic eve	2	19a. Informant's Name/Relations			10h Mailin	n Address (Stre	et and Numbar or Ru			State 7in	Code)
27 is or trau		Dennis N. Duri					pple Turn				
Department of Health important: if item 27 any Injury or other tr once.		20a. Method of Disposition		20b. F	Piace of Dispo	sition (Name of	April 1	Date	20c. Location		
ant of the ry or		1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S					emetery	.7, 1998		Marlh	oro, Md
oortan Inju		21. Signature of Funeral Service					rass of Facility Lec	Funera			
OF ES		1 12	-				Ferry Ro				
nysician Medical xaminer	4	23a. Party Enter the disease, or shock, or heart failure. List Immediate Ceuse (Finel disease or condition rasulting In death)	only one caust on ea	eff	Vex.	trial	/	ilune			Approximete intervel Between Onset and Death Muluuts Muluuts
	Je		a	1. 100	MAL	uence oi):	0 0	10 act			Mount
physician end s the burial-transit	Examiner	Sequentially list conditions.	6U	Dua to (d	or as e conseq	carron	V LU	fancus	h		valoury
ian e urial-l		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disease or injury				uence of):	,	J			
ng physician end s es the burial-tran	edicai					uence of):					
ing pt	4	that initiated evants resulting In death) Lest	0.	Due to (o	er as a consequ						
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attendir for use		that initiated evants	d	Due to (o	er as a consequ						
the ettendir		that initiated evants				uence of):	jiven In Part I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
ed by the ettendir detached for use	Physiclan/	resulting In death) Lest				uence of):	given In Part I.				
been signed by the ettendi should be detached for use	by Physiclan/	resulting In death) Lest				uence of):	jiven In Part I.	1 □		3 Prol	
hes been signed by the ettendi je 2 should be detached for use	by Physiclan/	resulting In death) Lest				uence of):	iven In Part I.	1 - 24a. Was	Yes 2□ No an autopsy ormed?	3 Prol	ere autopsy findings elieble prior to mpletion of ceuse death?
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ate hes been signed by the ettendi page 2 should be detached for use	Be Completed by Physiclan/	resulting In death) Lest Part II, Other significant condition		th but not res		uence of):	26. Place of Das	24a. Was perfe	Yes 2 No	3 Prof	ere autopsy findings elieble prior to mpletion of ceuse death? Yes 2 No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #5, 4/23/98, C.W.C., Kent Co. Certificate of Death Reg. No. -1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth April **Physician** 7, Robert Newton Ellis II 10:10 p.m. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 610 High Street Chestertown Kent 5. Sociel Sactity Number 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Birthplece (Stete or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Yeer) 10XM 2□ F Months Devs Hours 220-82-0062 Director 65 January 1, 1933 Retterton, MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location ma 23a or 28a-f show man be notified at 10d. Inside City Limits NO Yes 2 No Funeral Director Maryland Kent Chestertown 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? death with Items 23a 610 High Street 21620 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mentel Hygiene. Important: if Itam 27 is marked other than "neary injury or other traument." 12. Wes Decedent Ever in U,S. Armed Forces? 20AYes 2 □ No If Yes, Give Yeer or Detes: 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Be Completed by 3 XWidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Self Employed Electronic Technician 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Robert N. Ellis, Sr. Florence Ester Willis 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia Davis/Daughter 1679 South State St. #87 Dover, DE 19901 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burlel 2 XCremetion 3 ☐ Removel from State Chesapeake Cremation Center IIC/April 8, 1998/Stevensville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 allow that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) CUEMETS /Medical 4/3/98 Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest use es the buriel-trer Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? NUT AVALLABLE 1 Yes 2 No 3 Probably 4 Unknown þ Be Completed 25. W 27. M

To the Hospital or Attanding Physician: The law requires thet the death certificate be execu within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the extending physician end Division of Vital Records, P.O. Box 68760, Certification: To filled in by

					24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
es case referred to medical				26. Plece of De	eeth (Check only one)	
Yes 2 No	Hospitel: 1 ☐ Inpatient 2 [ER/Outpetient	3□ DOA	Other: 4 Nursing	Home 5 Residence 6 □Oth	er (Specify)
enner of Deeth Neturel 5 Pending Accident Investiget		28b. Time of Injury	28c	Injury et Work?	28d. Describe how injury occurr	red
☐ Suicide 6 ☐ Could not determine		nome, ferm, stree ify)	t, factory, o	ffice	28f. Location (Street and Numb City or Town, State)	per or Rurel Route Number,

Signature and title of certifie

29c. License number D360ry 4/16

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

120 Speer Rd. Cheskstown, MD 21620 atrick J. Shanahan, M.D. 31. Dete filed (Month, Dey, Year)

State Registrar

Medicai

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death April 7, **Physician** 1998 4:45 PM Easton Edna Arleah /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Bowie Prince George's Larkin Chase Nursing Home 5. Sociei Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Aug 23, Year 917 7. Aga (In yrs. last birthday) 6. Sax **Funeral** 1□ M 2√F Months Deys Hours Evergreen, Pa 80 Yrs. Director 150-32-0447 Usuel Residence of Decedent death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at MD Prince George's Bowie Director 1 ☐ Yes a No 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code United States 20715 14020 Lancaster Lane Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yas, Give Yaer or Datas: Wes Decadent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mantel Hygiena. Important: if Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Examina-1 Never Married Married Baltimore, Maryland 21215-0020 Specify White 1 ☐ Yas 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Health Care Register Nurse 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Jenny Huffman Fred Corson 20 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 14020 Lancaster Lane, Bowie, Maryland 20715 19a. Informent's Name/Reletionship (Type, Print) George Easton (HUSBAND) 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Lee Crematory April 8, 1998 Clinton, Maryland 21. Signeture of Funeral S 22. Name and Address of Fecility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Lõ ac Z 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haert feilure. List only one cause on each line. Intervel Between Onset end Deeth Physician 1 8 Iseal Immediate Ceuse (Finel disease or condition resulting in death) /Medical Wee Examiner Due to (or es a consequenca of) Examiner attending physicien and for use as the bunal-transit the death certificeta be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequença of): P.O. Box 68760 Physiclan/Medical thet initiated events Due to (or es a consequence of) resulting in deeth) Last 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown The law requires that Division of Vital Records, p 90 24b. Were eutopsy findings 24e. Wes en eutopsy Completed evailable prior to completion of causa of deeth? has After this certificate 1 Yes 2 No 1 ☐ Yes 2X No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: i or Attending P XX Neturel 5 Pending investigation Injun after deeth.

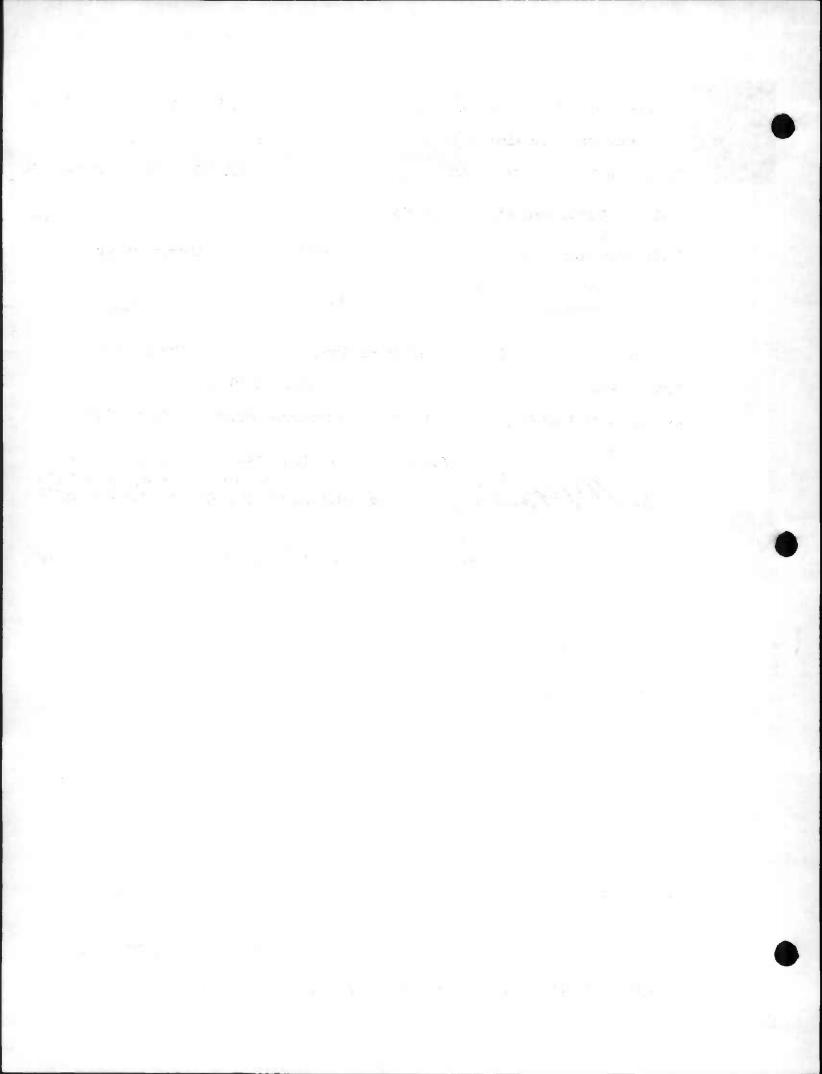
Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di complately filled in 29a. Certifier 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the tima, date and plece, end dua to the cause(s) and menner steted. Medical (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifiar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) David L. Siegel, M.D. 3231 Superior Lane #A6, Bowie, Md. 20715 Day, Year)

32. Registrer's Signeture

APR 1 5 1998 Duli Shucker Rendek 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95



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					viaiyiai		tificate of		wentai ny	Reg. No.	129	969	
Phy	ysicia	ın	Decedent's Name (First, Middle, Maude Eunice	,					2. Date of D Month	Day 10	Year	Time of Death	
//\	Jedic	al	4a. Fecility Name (If not Institution,		arl			4b. City, Town, or	Location of Doc			a.m.	
FX	amin	er	Chestertown Nu			tation		Chester					
Fund Direc	_		5. Social Security Number 220-16-7666 Usual Residence of Decedent	5. Sex 7 1 ☐ M 2 ☐ F	Age (In yrs. 95	last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplace Country) MD	(State or Foreign	
dand wo	11		10a. State 10b. County 10c. City, Town or Location							10d. I	nside City Limits		
Mary a-f sh	Tied.	tor	MD Kent	-	Ro	ck Hal	1					I ☐ Yes 2 🛣 No	
th with the Maryland	ast be not	al Director	10e. Street and Number 6412 Rock Hall I	Road			10f. Zip Code 2166	1		-	of What Country?		
72-0020 72 hours after death with the Maryland "natural", or Items 23s or 28s-f show	Standing m	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force d 1 1 Yes 2 If Yes, Give Year or Dates	s? ⊠ No	11	Vas Decedent of I Yes, specify Cub ☐ Yes 2 No		Specify Yes or Note Ricen, etc.)	0- 14. Re Bla Specia	oce - Americen Indian, ack, White, etc.		
within ene.	the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 7 th College (1-4or 5+)			(Give I life. D	ent's Usual Occup kind of work done DO NOT use retire SEWOYK	during most of wa	orking	16b. Kind of E Priva Famil	Business/Industr	usiness/Industry te	
e filed other	event,	Be C	17. Father's Name (First, Middle, La	ist)		nou	BEWOIR	18. Mother's Na	me (First, Middle	, Maiden Sumai	me)		
0 0 0	tic ev	ToB	James Henry Wesl	.ey					Margare				
A d d	or other traumatic		19a. informant's Name/Relationship George R. Wesley		phew	19b. Mailin 3221		end Number or R			or Town, State, Zip Code)		
permit. Peges 1 an Department of Heal Important: If frem 2	iry or oth		20a. Method of Disposition A Burlal 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Theilional Itolii State			atory or other pla		Date 4/18/98		20c. Location - City or Town, State Rock Hall, MD		
permit. Departm Importa	any injury once.		21. Signature of Funeral Service Lie	_		22.	Name and Addre	sa of Fecility J	ames A.	Perkins	Funera	1 Servi	
Physici	ian		23a. Part1. Enter the disease, or co shock, or heart failure. List or		ed the death illne.	. Do not ente	or the mode of dyle	ng, such as cerdia	c or respiratory e	errest,	Inte	proximete rval Between set end Death	
/Medi Examir	cal		Immediate Cause (Final disease or condition resulting in death)	a		Goo U	ras cult	ar di	Sias	e	Sec	reml reals	
D -	<u> </u>	ner		_	200 10 (01	us u 0011354	derice or j.	, ,			1		
tificate be executed g physician and	ounal-tran	II Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	0.	Due to (or	as a consequ	as a consequence of):						
ath certificate be exattending physician	ise as me	8	that initiated events resulting in death) Last										
death certi	Total :	Clar	Part II. Other significant conditions	contributing to death	but not recu	Iting in the up	dorhina cousa ah	ion in Rod I	22h Did	tohanna waa a	and dhute to the	cause of death?	
signed by the a	a petache	by Physician/M	a a	contributing to death	50111011630	iting in the on	oenying cease giv	en in Pett i.		Yee 2 No		4 Unknown	
aw requ	s should b	Completed							24a. Wes	en eutopsy ormed?	avallebl	utopsy findings e prior to tion of cause 1?	
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or Attending Physician: effer death. Director: After this certification in by the fundral director.		clon: 10	1 Yes 2 No 27. Manner of Death 1 Nature 5 Pending 2 Accident investigat	28a. Dete of In (Month, D	jury	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	4 LEU-Mursing F	flome 5 ☐ Residence 8 ☐ Other (Spec 28d. Describe how Injury occurred				
al or Attending Physics effector: After this add in the translation of	in ko iii pa	Certification	3 Suicide 6 Could not determine	be 28e. Place of Ir	njury - At hor etc. (Specify		et, factory, office				ber or Rural Rou	te Number,	
To the Hospital or A within 24 hours effer To the Funeral Director Completely filled in h	mi Kieserd	eg lea	29a. Certifier Certifying F (Check only one)	Phyaician: To the bes aminar: On the basis and manner s	of examinati	fledge, deeth on and/or inve	occurred et the tin estigation, in my o	ne, dete end place pinion, death occu	o, end due to the irred at the time,	cause(s) and me date end place,	enner es stated. and due to the	ceuse(s)	
To the	3	-	29b. Signeture and title of certifier				29c. Licens	e number		29d. Dete signe	d (Month, Day,	Year)	
				waun	-		200	357		4/16	148		
			30. Name and address of person who	completed ceuse of	deeth (Item	23a) (Type, P	CHEST	GRIDIN	o, met	21620			
	State sistra	1	31. Date filed (Month, Day, Year) APR 16	32. Regis	trar's Signat	vidson-A	andelle						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	*					, , ,	Ce	rtificate o	f Death		Reg. No.		2970
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ı	Funeral Director		019-01-5285 Usual Residence of Dec		SAX 1 ZM 2 F	76	last birthday Yrs.	Months Dey			iv. Year) 4, 1921	9. Birthp Cour Hartfo	oleca (Stata or Foreign ord, CT
	e Maryland la-f show		10e. Stete 10b	. County		10c. C	ity, Town or L	ocation				1	10d. Inside City Limits
		ctor	Maryland I	Kent		Ga]	ena						1 ☐ Yes 2 ☐ No
	or 24	Dire	10e. Straat and Number					10f. Zip Coda			10g. Citizen of	Whet Coul	ntry?
	s 23a	ral	11263 Carrol1	Clark R	Dad 12. Was Decede		2163				U.S.A.		
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5-0		Completed	15. I (Specify or	Decedent's Ed	ducation ade completed)		16e. Dece	dent's Usual Occ	upation e during most of wa	orkina	16b. Kind of B	usiness/in	dustry
2121	vithin ne. hen	mpi	8 Elementery/Secondery	1	College (1-4	or 5+)			e during most of wo	nning			
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<u>m</u>	Pages mant of P ant: If Ite ury or of		4 Donetion 5						Ctr.,LLC/A	pril 13, 1	998/Steve	nsvill	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health end Mental Hygiene. Important: If Nem 27 is marked other than any injury or other traumatic event, IT M 00008.		21. Signetura di Fineral	AN	lich,	in		20 Channe -	elfenbein, &	14D	21 (20)	me, P.	Α.
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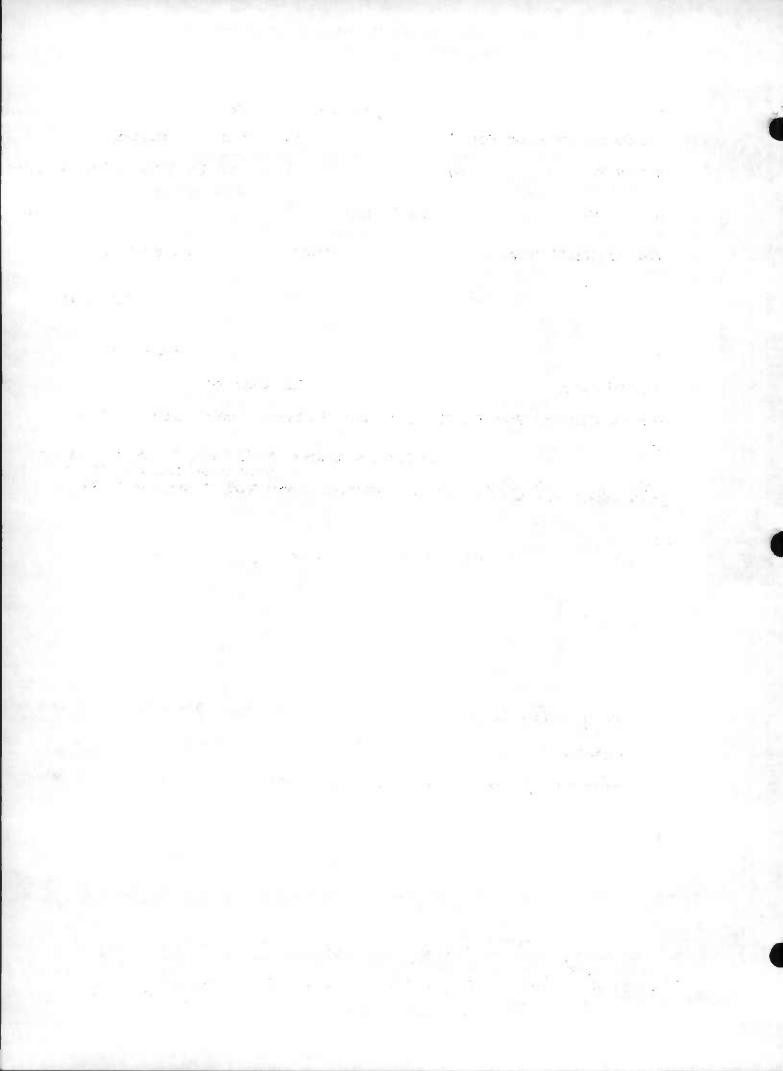
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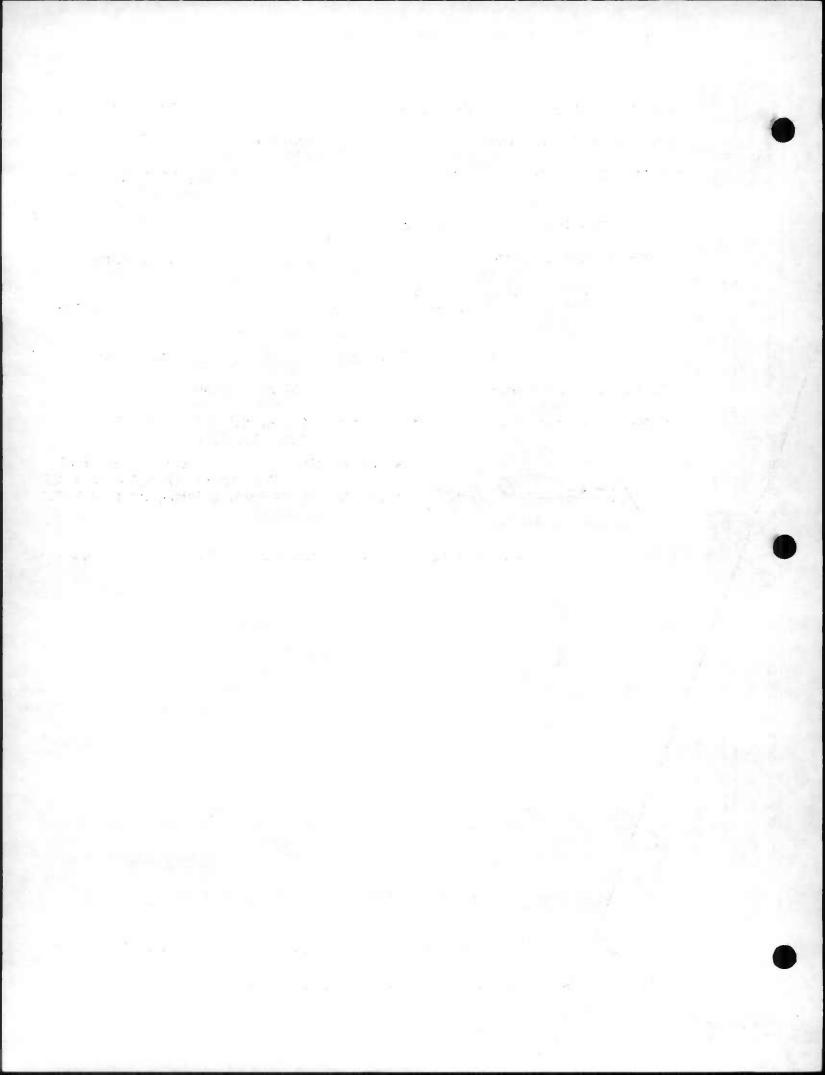
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DHMH 16 Rev 6/95



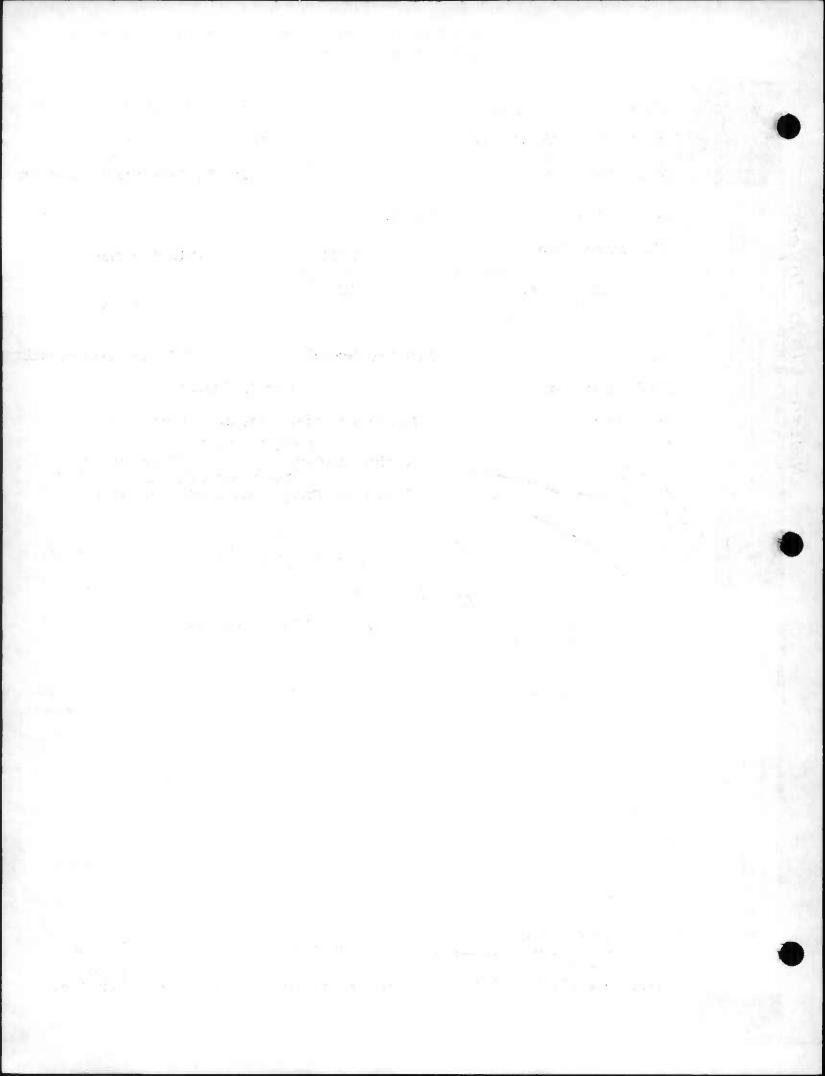
State of Maryland / Department of Health and Mental Hygiene

							Cei	rtificat	e of	Death		F	Reg. No.	16	2912	
			1. Decedant's Nama (F	irst, Middla, Las	it)							2. Date of Dea		Vana	3. Tima ot Death	
	Physicia		ROBERT	Arthur	G	RANZEN,	SR					APRIL	12,	1998	9:40pm	
4	/Medic Examin		4a Facility Nama (If no							4b. City, To	wn, or Lo	ocation of Death	4c. County			
	was in		5909 PAR	ROT FI	SH COU	RT				WAL	OORE	•	CHA	RLES		
	Funeral		5. Social Security Numl			. Aga (In yrs. last	birthday)	It Undar Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, De)	Vear	9. Birthp	laca (Stata or Foraign	
П	Director		141 09 343	2 1	XM 2□F	80	Yrs.	MOITING	Days	Hours	IVIII.			New		
	P .		Usual Residence of Da			1.0 01 =										
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	₽ 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	듬	10e. Street and Numbe					10f. Zip	Coda				10g. Citizan of	What Coun	itry?	
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	er de	Funeral Director	11. Maritel Status		Armed Ford		13.	Was Deced It Yas, spec	dent of F cify Cub	Hispenic Or an, Mexical	igin? (Sp n, Puarto	ecify Yas or No- Rican, atc.)	14. Rac Bla	ce - Amaric ck, White,		
20	S aft	by F	1 Navar Married 3 Widowed 4		f Yas, Giva	No Arm	-	1 Yas		Specify:			Specif			
8	hour	8				es1963-69		dent's Usue	X Occur	netion			16b. Kind of B		White	
21215-0020	d 2 should be filed within 72 hours after deeth with the Maryland thend Mentel Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified.	Completed	(Specify of	. Decedent's Ed only highest gra			(Giva	kind of wo	rk done	during mos	t of work	ing	TOD. KING OF D	usii lassii id	200119	
77	with ene.	E	Elamantery/Seconda 12	ry (0-12)	Collega (1-	4or 5+)		. Arm		-,			II C	71		
g	Hyg Hyg Sther ent,	O	17. Father's Nama (Firs	st, Middla, Last)			0.0) - ALII	ī¥	18. Moth	ar's Nem	a (First, Middle,		Army		
Maryland	id be entel kad c	o Be	Arthur N	icholas	Granzen					Al	ice (Chapman				
37	Should Mind	-	19a. Informant's Name				9b. Meili	ng Address	(Street			al Routa Numbe	r, City or Town	, Stete, Zip	Coda)	
_	end 2 ealth e n 27 ls		Robert A.	Granzer	ı, Jr.		6313	Fur	Sea	1 Cou	rt, I	Waldorf	Md 20	603		
re,	of Health of Health I Item 27	r	20a. Mathod of Disposi			20b. Place						6,001€998			wn, Stata	
more,	oemit. Pages 1 end Department of Health mportent: if Item 27 eny Injury or other to		1 Burial 2 C 4 Donation 5			late		tion					Clinto			
a	permit. Page Department of Important: If eny Injury or pace.		21. Signature of gunera			. //					M ee	Funera.				
Ö	Depa Impo eny I		1	-	14.	Hott						ad, Cli				
	-	\dashv	23a. Part 1 Entar tha c shock, or haart te	lisaasa, or comp	olications that co	used the death. D						•		2	Approximata	
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	Examiner		disaasa or condition resulting in deeth)		a. PROST	ATE CAN			пр	ONE	MEIA	ATASTS			42.	
		ner				Dua to (or as	a corrse	quarice or).								
	The law requires that the death certificate be executed the hes been signed by the attending physician and page 2 should be deteched for use as the bunal-transit	edical Examiner	Sequentially list condit	ions	b	Dua to (or as	a consac	guance ot):								
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	death ed fo	Physician	Pert II. Other eignificar	nt conditions co	ontributing to das	th but not resulting	g in tha u	indarlying o	ausa gi	ven in Pert	l.	23b. Dld 1	obacco uaa co	ontributa to	the cause of death?	
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ord	v requires that the de been signed by the should be deteched	b d											en eutopsy rmed?	av	ara autopsy tindings ailabla pnor to	
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2	Attending Physician: or death. or ther this certific by the funeral director,	2	1 Yes 2 No		Hospital: 1 ☐ In	petiant 2 ER/	Outpatie	nt 3 D	DA Ot	har: 4□ N	ursing Ho	oma 5 Hesio	dence 6 □Ot	her (Specif	'y)	
Division of	ng Pt ter th		27. Manner of Deeth 1. Natural 5	Panding	28a. Deta of (Month	Injury 281 Day Year)	. Tima o Injury	ot 2	28c. Inju Wo	ry at ork?		28d. Dascribe I	now injury occu	rred		
0	death. ctor: Al y the fu	atic	2 Accident	invastigation		3 333		М	1]Yas 2□	No					
ž	or Atte	Ĕ	3 ☐ Suicide 6 4 ☐ Homicida	Could not be datamined	28a. Place	ot tnjury - At homa, g, atc. (Spacify)	tarm, st	raat, tactor	y, office			28f. Location (S City or Tox		ber or Rura	al Routa Number,	
	rs eff	Certification:														
	To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: After this cartificete he completely filled in by the funeral director, page	edical	29a. Cartifier 15 (Check only 2	Certifying Phy	yalclan: To tha b	est of my knowled is of axamination	iga, daat	h occurred	at tha ti	ima, deta ai	nd place, ath occur	end due to the	causa(s) and m	annar as s	tated. o tha cause(s)	
	the H		one)		and manna											
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					epartment of F Certificate of			Reg. No. 9	3	2973
Physici		Decedent's Name (First, Middla, L Nelson Llc	oyd Myers				2. Date of Do		9 ^{Year}	3. Time of Death $10:40\text{ AM}$
/Media Examin		4a. Facility Name (If not institution, g	va street and number)			4b. City, Town, or				100000
		Civista Medic				La Pla			rles	
Funeral Director		5. Social Security Number 6. 229–34 7853 Usual Residence of Decedent	1 N 2 D E	e (In yrs. last birti 1	nday) If Undar 1 Yaar Months Days	If Under 24 Hrs Hours Min	8. Date of Bi (Month, D Jan 2	rth a <i>y, Year)</i> 7, 1927	9. Birtho Cour Harri	elace (State or Foreign etry) Sonburg, V
eath with the Maryland ne 23a or 28a-1 show	7	10a. State 10b. County MD P.G.		10c. City, Town					1	0d. Inside City Limits
or 28a-f	recto	10e, Street end Number		CIII	10f. Zip Code					
h with	al Di	9113 Simpson La	ane		2073	5	10g. Citizen of What Country? United States			
5-0020 72 hours after death with the Maryland netural; or thems 23e or 28e-1 show lical Examined must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married ♣️○♠️Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant I Armed Forces? XX Yas 2 N If Yes, Give Year or Datas:		13. Was Dacedent of H If Yes, specify Cub 1 Yas 2 No	dispanic Origin? (S an, Maxican, Puer Specify:	Specify Yas or Note Rican, etc.)		ce - Americ ck, White, y: White	etc.
Z = = =	Completed	15. Decedent's I (Specify only highest g Elementery/Secondary (0-12)	Education rada completed) College (1-4or 5	i+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wo d)	rking	16b. Kind of B	usinass/ind	dustry
CV TO TO LAND	Co	12 17. Father's Name (First, Middle, Las	t)	Aiı	craft Mech		me (Eiret Middle	U.S. A		ansportation
ld be the stand of ceve	To Be	Lloyd Click Mye	•				F. Shar		iia)	
re, Maryland stand 2 should be flied from the down the flow that hy other traumatic event,		19a. Informant's Name/Relationship Jean Myers			Mailing Address (Street	and Number or R	ural Route Numi	per, City or Town,		,
Baltimore, Inwinit. Pages 1 and Papartment of Health Inportant: If item 27 my injury or other times.		20e. Method of Disposition f Burial 2 Cremation 3 4 Donation 5 Other (Spec			Disposition (Name of , crematory or other placection Ceme		18, Dat 1998	20c. Location -		
Ball permit. Depart Import any inj ance.		21. Signature of Funeral Service Lice	nsee	7	22. Name and Addre Alexandria					
Physician /Medical Examiner	(Enter the disease, or constitute. List only shock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death)	nplications that caused perio cause on each lin	the death. Do no	t enter the mode of dyir	ng, such as cardia elif In	correspiratory i	urrest,		Approximate interval Between Onset and Death
D 4	Examiner		b 4	Due to (or as a co	ensequence of):	,				years
ox 68760, certificate be selecu- inding physician and use as the burial-tra-	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease or injury that initiated events resulting in death) Last	· W	Due to (or as a co	onsequence of):	Depen	deid	Darbeer	5	year
Box (death certification of for use a	lolan	Part II. Other eignificant conditions	nontributting to donth h	ut not requiting to	Nh a coadadeir - aacca ab	en in Deat	l not pid	Anh		all a subsect of decade 0
15, P.O.	by Physician/M	Part II. Other eignincant conditions	/an in Part I.	23b. Did tobacco use contribute to the cause 1 Probably 4						
COTC requi	Completed							s an autopsy ormad?	av	ere autopsy findings allabla prior to mpletion of ceuse death?
f Vital Re(ysiclan: The law is certificate has director, page 2							10	Yes 2 No	10	Yes 2 No
Vit siclar s certif directo	To Be	25. Was cese referred to medical examinar? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2☐ ER/Out	patient 3 DOA Oth	er'	ath (Check only	ona) idence 6 □Oth	or (Consit	w)
n of g Physical distribution	T:U	27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injur (Month, Da)				1	how injury occur		//
Division of Vita With the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	on			Yes 2□No	28f. Location City or To	(Street and Num.l wn, State)	ber or Rura	l Route Number,
Hospital c 24 hours a Funeral D stely filled i	edical Ce	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa	miger: On the basis of	examination and	death occurred at the tir or investigetion, in my d	me, dete end place	a, end due to the	ceuse(s) and mo	enner es si and due to	teted. the ceuse(s)
To the within ? To the comple	Mec	29b. Signature and title of partitler	and mannar sta		29c. Licans	a number		29d. Data signe	d (Month,	Day, Year)
		30. Name end address of parion who Daniel Howell 31. Date filed (Month Cay York)	MD 11345	Pembr	ivena Print)		e 104	Waldor	20 f,Ma	603 ryland
Sta Registr		JI. Date med (Michili, Dey, 1941)	32. Registra 5 1998	U S-SUIDUU(e)						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						Certif	cate of	Death	R	leg. No. 9	3 1	2974	
П	Physic	ian	1. Decedant's Nama (First, Middla, Las						2. Data of Dea Month		_Yaar	3. Tima of Death	
	/Medi		Helen Creel		ceall					13, Day 199		10:45 PM	
	Exami	ner	4a. Facility Nama (If not institution, giva Mariner of South		ınd			4b. City, Town, or L Clintor		4c. County		rge's	
	Funeral Director		210 10 020,	7. Aga ((In yrs. last t		Under 1 Year onths Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth Month, Day June 6	Year		aca (Stata or Foreig Ington DC	
1	Maryland -f show	tor	Usual Rasidanca of Dacedant 10a. State 10b. County P.G.	1		own or Location Washi					10	od. Insida City Limits	
	th with the 23a or 28i	al Direc	10e. Street and Number 7214 Webster Lar	ne		1	Of. Zip Coda 2074	4	1	10g. Citizan of What Country? United States			
21215-0020 d within 72 hours after death with the Manyland glene. rr then "natural", or items 23s. or 28s-f show	ours after deat al', or items 2	by Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed ♣️□ Divorced	12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas:			Decedant of I s, specity Cub ras 2 No	Hispanic Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No- Rican, atc.)		ce - America ck, White, a		
5-0	72 ho	eted	15. Dacedent's Edu (Spacify only highast grad		16	Sa. Decedent'	S Usual Occup	pation during most of work	cina	16b. Kind of B	usiness/Ind	ustry	
121	within ane. then "	Completed	Elementery/Secondery (0-12)	Collega (1-4or 5+)	н	iiia. Doi		during most of world)	9	Beauty	,		
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.	d be filed and that Hygie ed other it event, it	Be	17. Fathar's Nama (First, Middla, Last) James Creel Pyle	2S	11	all bi	CSSCI	18. Mother's Nam	a (First, Middla, Sertrude	Maidan Suman	na)	8	
	d 2 should hand Me	To	19a. Informant's Name/Reletionship (7) Helen G. Pyles				and Number or Ru	ral Routa Numbe	r, City or Town,	, Stata, Zip			
	ages 1 end nt of Healt If item 27 or other 1		20a. Mathod of Disposition 1 Surial 2 Cramation 3 1	20b. Placa	of Dispositio	(Nama of	Lane, For	Data	20c. Location -	City or To	wn, Stata		
Baltin	permit. Pe Depertment important any injury		4 ☐ Donation 5 ☐ Other (Specify, 21. Signeture of Fuñaral Sarvice Licent		//	dar Hill Cemetery April 17, 1998 Suitland, Ma 22. Name and Addrass of Facilities Funeral Home, Inc 6633 Alexandria Ferry Rd, Clinton, Md 20735					33 Old		
			23a. Part I. Enter the diseasa, or comp shock, or haart feilura. List only o	lications flux caused th	a death Do						20735	Approximata	
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oʻ	tificete be executed ig physician and es the burial-transit	Exami	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaasa or Injury	b	ue to (or as a	a consequand	e of):				1		
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VIII S	Physician: The this certificate ral director, peg	B	25. Was casa referred to medical exeminar?	Hospital:			low	26. Placa of Dea					
ō	Phys this ral di	. To	1 ☐ Yas 2 🕱 No	1 LI Inpatiant		Outpatient 3 Tima of	LI DOA		oma 5 Rasid)	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Panding 2 Accidant invastigation 3 Sulcida 6 Could not ba	28e. Deta of Injury (Month, Day Y		fnjury F		rk? IYas 2□No	28d. Dascribe how Injury occurred				
<u>N</u>	7 4 4 5	Certif	4 Homicida datarmined	28a. Place of Injury building, atc. (- At homa, (Specify)	farm, straat,	actory, offica			cation (Straat and Number or Rural Routa Number, ly or Town, Stata)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Cartifiar (Check only one) 1 Cartifying Phy 2 Madical Exami	sician: To the best of n ner: On the besis of ex and manner stated	camination a	ga, daath occ and/or Invasti	urred et tha ti gation, in my o	ma, data and plece, opinion, deeth occur	and due to the or red at tha tima, o	eusa(s) and ma lata and pieca,	anner as st and dua to	atad. tha causa(s)	
	To the To the comp	Me	29b. Signatura and titla of cartifiar	K			29c. Licans	sa numbar 46478	- 2	29d. Data signed (Month, Day, Year) U-1U-98			
•			30. Name and address of person who con Suresh A. Paul	elinin.	70	2015	man H		307			D 2073t	
	Sta Registi		31. Data filed (Month, Day, Yaar)	32. Registrate	Signatura	des Ren	Lath		<u> </u>	711,100	, 111	20170	
Div	UU 46 Day 60	c	73 11 7 0	0									

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Wallace Doris Frances 1859 1998 April 12 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Kent & Queen Anne's Hospital 5. Sociel Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Date of Birth (Month, Dev. Year) 1 M 2 F Deys Hours 220-26-9738 65 Yrs. MD 11-27-32 Usuel Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits WORTON 1 ☐ Yes 2 ₽ No KENT 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11338 WOOD 21678 USA ALLACE 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 25 Married 1 ☐ Yes 2 III No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10TH DOMESTIC HOUSEWORK 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ALBERT DORSEY OLIVIA TILLER 19a, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. PERLEY WALLACE. HUSBAND 11338 WALLACE WOOD RD. WORTON, MD 21678 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State WORTON, MD NCCOL CEMETERY 4-18-98 4 □ Donetion 5 □ Other (Specify) ire of Funeral Service Licensee 22. Name and Address of Facility WALLEY FUNERAL HOME 207 CAWERT STREET. CHESTERTOWN MD disease, or complications that caused the death Do not enter the mode of dying, such as cardiec or respiretory errest, failure. List only one cause on each line. Arteriosclerotic Cardiovas cular Disease Immediate Cause (Final disease or condition resulting in death) 14cars Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of):

Physician /Medical Examiner

Department of important: If eny injury or

Physician

/Medical

Examiner

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Completed by Funeral Director

Be

Funeral

Director

Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, in Medical Evantical inter the nutified at

Baltimore, Maryland 21215-0020

the buriel-trensit

Hospital or Attending Physician: The law requires that the death certificata be executed

After

24 hours after death.

Division of Vital Records, P.O. Box 68760,

Examiner Completed by Physician/Medical Be Medical Certification: To within 24 hours after dea To the Funeral Director complately filled in by the

Pert II. Other significant conditions of				23b. Did tobacco usa co 1 □ Yss 25 No	ntributa to the causa of death
An pertensi				24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
25. Wes case referred to medical exeminer?			26. Place of D	eeth (Check only one)	
1 ☐ Yes 2 ☐ ♣io	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetlent 3250	OOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Oth	er (Specify)
27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury et Work? 1 □ Yes 2 □ No	28d. Describe how Injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fectorify)	ory, office	28f. Location (Street end Numb City or Town, Stele)	per or Rural Route Number,
29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my known inner: On the basis of examine and menner steted.	owledge, death occurred etion end/or investigation	d at the time, dete end plean, in my opinion, deeth occ	ce, end due to the cause(s) end me curred et the time, date end plece,	enner es steted. and due to the ceuse(s)

Are Chostnoon Med 21620

State Registrar 31. Dete filed (Month, Dey, Year)

JUSAN K. ROSS, AD.

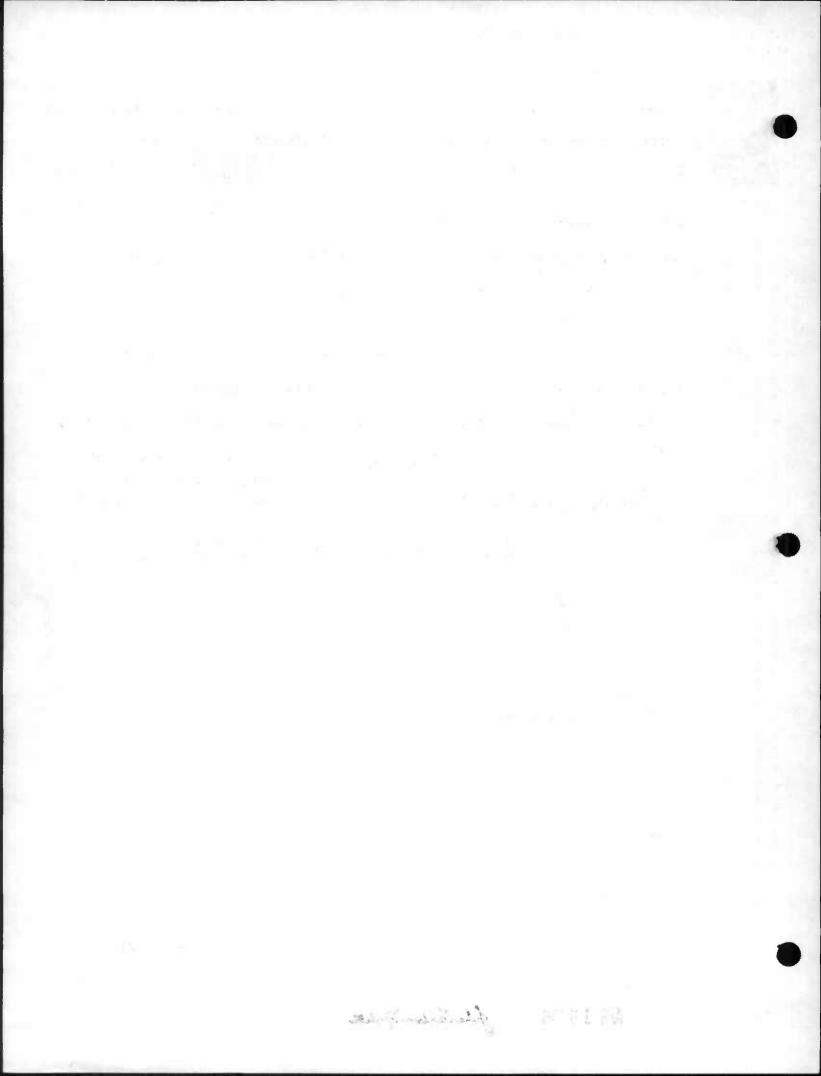
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nel argaret Flileen 98 April :00pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner If Under 1 Yaer If Under 24 Hrs. 8 Dete of Birth (Month, Day, Year) Mashinaton Georges Birthpiace (State or Foraign Country) 5. Social Security Number Sax 7. Age (In yrs. last birthday) **Funeral** 1□M 20XF Months 85 **Yrs** Director 236-12-1835
Usual Rasidance of Dacedant August 30,1912 West Virginia 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 TNo Director Maryland Charles form 23a or 28a-f-iner must be notifie Bryans Road 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6794 Amherst Rd. 20616 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 11 Maritai Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Race - American indien, Bieck, White, etc. traumatic event, the Medical Examiner 1 ☐ Nevar Married 2 ☐ Merried 6 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Datas: Specify: Specify: White þ 3 Widowed 4 □ Divorced "natural". Completed 16b. Kind of Businass/Industry 15. Decedant's Education 16e. Decedent's Usuei Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) (Specify only highest grade completed) Hygiene. Elemantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) h and Mental h Pages 1 and 2 should be Thomas Walsh Anna Donnely 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret McCaffrey Daughter 401 South Court House Rd., Arlington, Va. 22204 mportant: If Item 27 20b. Place of Disposition (Nama of cematary, crematory or othar place) April 15, 1998 20a. Method of Disposition 20c. Location - City or Town, Stata ъ 1 Burial 2 □ Cramation 3 □ Remove from State 8 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 22. Name and Address of Fecility
Williams Funeral Home, P.A. 21. Signeture of Funaral Sarvice Licensee M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hour failure. List only one cause or each line. Approximata intarval Batween Onset end Death Physician /Medicai immediata Cause (Finel disease or condition rasulting in daath) Examiner equence of) Examiner mi/ physicien and the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consequence of) Physician/Medical that initiated events rasulting in death) Last Dua to (or as e consequance of): 88 for use as signed by the e Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 has 212 No 1 Yes 25 No certificate director, 25. Was cesa rafarred to medical axaminar? Be 26. Piaca of Daath (Check only ona) Hospitai: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) P 1 Yes 2 No 1 Nopatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death

1 Natural

2 Accident 28a. Date of injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Hospital or Attending P
 24 hours after death.
 Funeral Director: After i Certification: 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida 29a. Certifiar Medical 🔼 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Margaret Hilbern Wels

State Registrar (Check only one)

29b. Signature and title of certifier

ess of person who complated causa of daath (ttam 23a) (Type, Print)

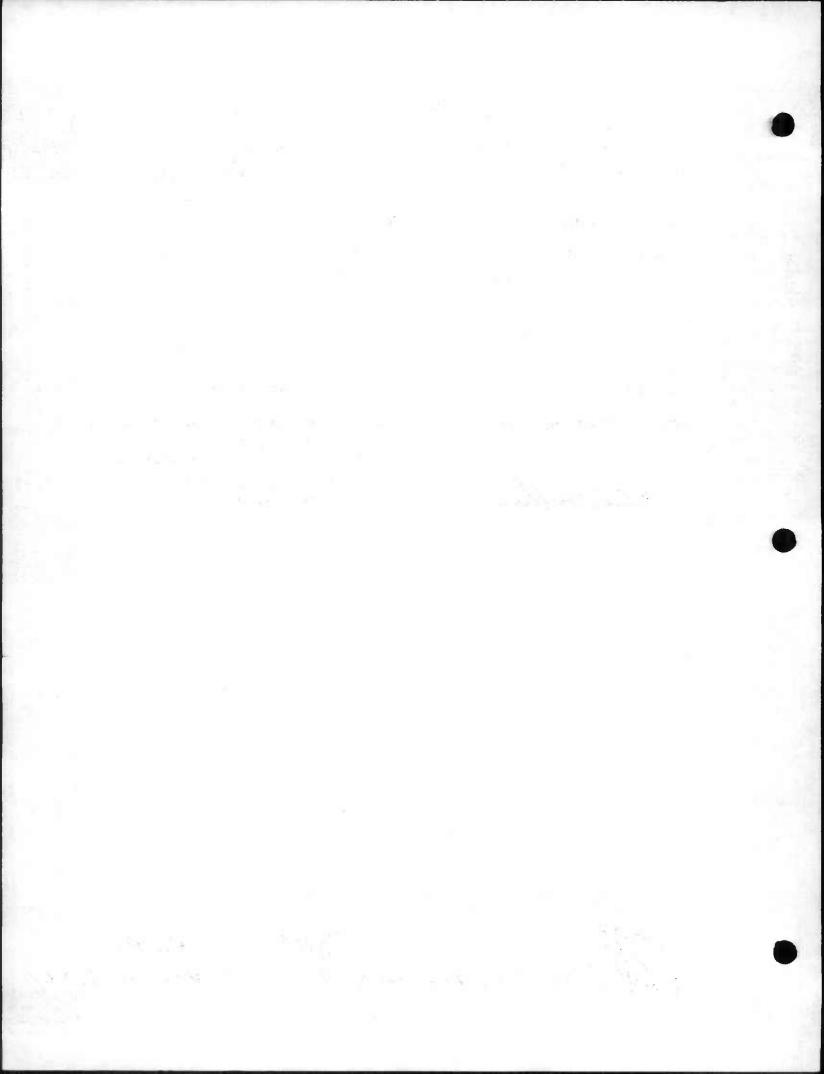
5 1998

101 32. Registrar's Signatura

Julia Davidson Rolls

DHMH 16 Rev 6/95

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Alfred John Webster 12, 1998 ath 4c. County of Death 6:00 AM April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hosptial Clinton If Under 24 Hrs Prince George's 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min Deys Hours 1 M 2 F Months 579 14 6875 Director Washington DC Oct 3, 1923 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10a. State 10h Counts 10c. City. Town or Location r 28a-f ahow s notified at MD 1 ☐ Yes 2 ☑ Nex Director P.G. Forestville 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? with I is marked other than "natural", or items 23a or traumetic event, the Medical Examiner must be a 7420 Marlboro Pike 20747 United States permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U,S.
Amed Forces?
APYes 2 No 194
If Yes, Give
Yeer or Detes: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1943 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□ Yes 2□No Specify. by 3 ☐ Widowed 4 ₺ Divorced 1947 White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) U.S. Military Army 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Herbert Webster Nola Pettingill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edwin Webster (BROTHER) 3006 Walters Lane, Forestville, Maryland 20747 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State XX Buriel 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery April 17,98 Suitland, Maryland 22. Name end Address of Facility ee Funeral Home, Inc 6633 Old 21. Signature of Picherst Service Licegate Alexandria Ferry Road, Clinton, Md 20735 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner physician and s the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet Initiated events resulting in death) Last P.O. Box 68760, Physician/Medical 98 950 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t by Division of Vital Records, 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of cause of deeth? page 2 certificate 10 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending efter death. 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours efter the Funeral Direct pletely filled in b 4 Homicide Hospital Descrifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as stated.

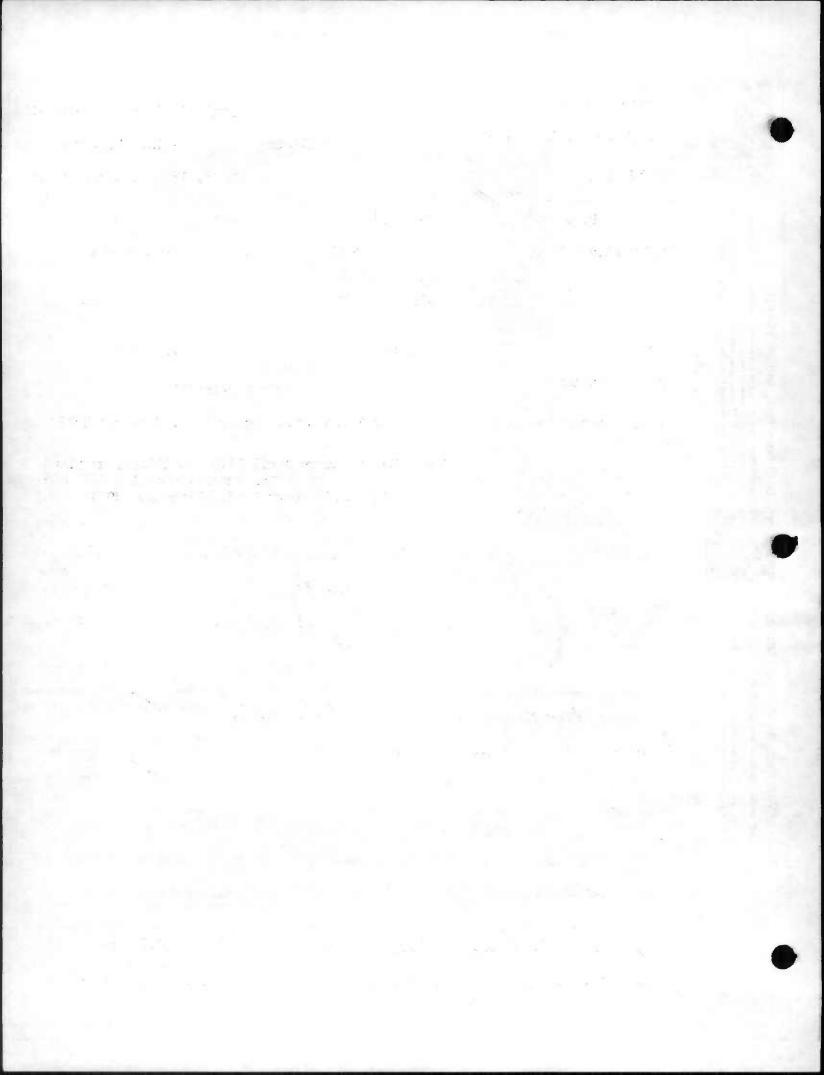
| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

1998 Registra

rs Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Ament Eleanor 1:43AM 04 20 1998 /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bayview Medical Contr Johns Hopkins Baltimore N/A Hours Min. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number if Under 1 Year 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) **Funeral** Days 1 □ M 20 F Director 220-03-8685 July 25, 1921 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? δ 820 S. Rose Street 21224 USA items 23a Funerai 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 72 hours efter 1 ☐ Never Married 2 ☒ Married 1 ☐ Yas 2 ☐XNo If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 δ 1 ☐ Yes XXNo Specify: White þ Specify: 3 Widowed 4 Divorced "natural", Completed traumatic event, the Medical 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within inent of Health end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 8th Housewife 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Joseph Ratajczak Catherine Waniecka 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health e: If item 27 is Andrew L. Ament, Sr. / Husband 820 S. Rose Street Baltimore, Maryland 21224 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Depertment of Important: If sny injury or once. St. Stanislaus Cemetery 4/23/98 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name end Address of Facility David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231 23a. Pert 1. Enter the disease. Complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. Approximata Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel . Middle Grebal Artery Stroke disaase or conditio resulting in death) Examiner Due to (or es e consequença of): Physician/Medical Examiner Mellitus Diabetes siclan end buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequance of) 14 ypertension
Due to (or as e consequenca of): Box 68760 physiclan IOYYS the thet initieted events resulting In daeth) Lest signed by the et d be deteched fo P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24e. Was en eutopsy performad? 24b. Were eutopsy findings availabla prior to completion of cause of death? Completed page 2 1 Yes 2 No Vital Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) To Hospital: Inpatiant 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA of this 27. Menner of Deeth Certification: 28c. Injury et Work? 28d. Describe how injury occurred Attending 5 Pending investigation vision Neturel 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after bear Funersi Director 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, tectory, offica building, etc. (Specify) 4 Homicide recrifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. Cal 29a, Certitier within 24 hor To the Fune completely fi (Check only one) 29c. Licensa number 29d. Date signed (Month, Dey, Year) Susan Holls M.D. 97017 April 20, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SUSON Hobbs M.D Johns Hopkins Bayview Medical Center 4940 Eastern Ave 21204

31. Date filed (Month, Day, Year)
32 Registrate Signature
32 1998 State

Registrar

and the second termination of the second ter Decree from the second of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: 23a Part Ibc Per MD Film G758 4-27-98RC Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death BROOKS **Physician** GERALDINE APRIL /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANKANISTOWN, HA BACTIMORE CO NORTHWEST HOSpitAl If Under 24 Hrs. 5. Social Security Number If Under 1 Year Age (In yrs. last birthday) **Funeral** Months Days Hours 218 10 1 □ M 2 ₩ 450 Yrs. Director MD Usual Residence of Decedant the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Expression results be notified at 1 □ Yes 2 □ No Director MD N/A BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 N. DURHAM ST 21213 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Execution 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: BLACK þ 3 Widowad 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOSPITAL 8th N/A HOUSEKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) Be MILTON JOHNSON SEDONIA JOHNSON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7008 PARIS RD SEDONIA WILLIAMSON BALTO, MD 21207 20c. Location - City or Town, State 7 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) APRIL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL CEM 1998 BALTO, MD 21. Signature of Funeral Service Licensae 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 atrecia 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner 4/12/98 the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a co The law requires that the death certificate be exec 4/12/98 P.O. Box 68760. HYPERKALEMIA Physician/Medical Due to (or as a consequence of): 8 ettending Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death. certificate has been signed by irector, page 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings Completed 24a. Was an autopsy performed? completion of cause of death? 21110 1 TYes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 3 No 1 Depatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Neturel 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could pot be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by

Records. Division of Vital

> State Registrar

completely

Medical

4 Homicide

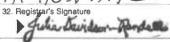
(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Dev. Yeer)

29a. Certifier

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)



1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the causa(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

MOS 1 (84)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Daath : 37A.M **Physician** Ruth Evelyn Britton April 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Rosedale Baltimore Franklin Square Hospital Center If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | July 14, 1918 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months 214-01-0943 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours aftar death with the ManJan if Health and Mental hygiens. The file file of the marked other than "naturel; or items 28a or 28a-1 show other treumstic event, the Monital Examines must be inclined at Maryland Baltimore Essex 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1101 North Marlyn Avenue 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forcas? 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yes 2 🔼 No If Yes, Give 1 Yes 2 No Specify: White Specify: P 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Nama (First, Middle, Maiden Sumama) Margaret Louise Tracey 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi lant: If itam 27 is marked oth Be J. Frederick Davis 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 1101 North Marlyn Ave. Essex, Md. 21221 19a. Informant's Nama/Ralationship (Type, Print) Paulette A. Greever (Daughter) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 Cremation 3 Removal from Stata 4/29/1998 Baltimore City Western Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Selvice Ligansus 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Enter the diseasa, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, theart failure. List only one chusa on each line. Approximate Interval Batwaan Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) a. Ventricular Tachycardia Due to (oras a consequanca of): /Medical Examiner Atheroscleratic Cardiovascular Disease Examiner Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 687 Due to (or as a consequenca of) 997 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed cartificate has b director, page 2 s 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Pleca of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 10 1 Yes 2 No this funeral 27. Mannar of Daath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending after death. Director: Aft 1 Yas 2 No investigation 3 Suicide 6 ☐ Could not be datarminad 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 24 hours 8 29a. Cartifiar (Check only one) Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely f

State

Registrar

Julie 31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

ruce And Casari no

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD 21237 32. Registrar's Signature Julia Davidson-Mandall

29c. Licensa number

D28214

29d. Data signed (Month, Day, Year)

April 26, 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) April Austin Matthew Baird :45 P.M 25. 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Baltimore Franklin Square Hospital Center edale 05 If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months 1 M 2 F Yrs N/a 21,1998 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Carney 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 3505 Field Creek Way S. A. 14. Rece - American Indian, 21234 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give A Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Matthew J. Baird Valerie N. Estes 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 085 19a. Intorment's Neme/Reletionship (Type, Print) Mrs. Phyllis Baird/Grandmother 1406 Old Joppa Rd. South Joppa, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Duriei 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Gardens of Faith Cem. 4/28/98 Overlea, Md. 21. Signature Fugeral Regrice Lig 22. Neme end Address of Fecility 1050 York Road Towson, Md. Ruck Towson Funeral Home 23a. Pert1. Enter the disease, or complication that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert teilure. Vist only one control on each line. Funeral Home, Inc. 21204 Approximete Intervel Between Onset end Death schemic Encephalopathy 4day S Immediate Ceuse (Final disease or condition resulting In deeth) lacental Abruption Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thal initiated events resulting in deeth) Last Due to (or es e consequence ot): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Y88 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause ot deeth? 24e. Wes en eutopsy 2 No 1 Yes 2 No 1 Yes 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rure! Route Number, City or Town, Stete) 4 Homicide

Physician/Medical Examiner requires that the death certificate be þ Completed peen The certificata Physician: Be P this funeral Certification: After t Attending i after death.
i Director: After de in by the fu filled in by 6 within 24 hours of To the Funeral (edical

Physician

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Examiner

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7 is merked other than "natural", or liens 23s or traumatic event, the Medical Examiner must be r

I Health and Mental Hygi Item 27 is merked other

Physician

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25. Wes case reterred to medical examiner? 27. Menner of Death

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated.

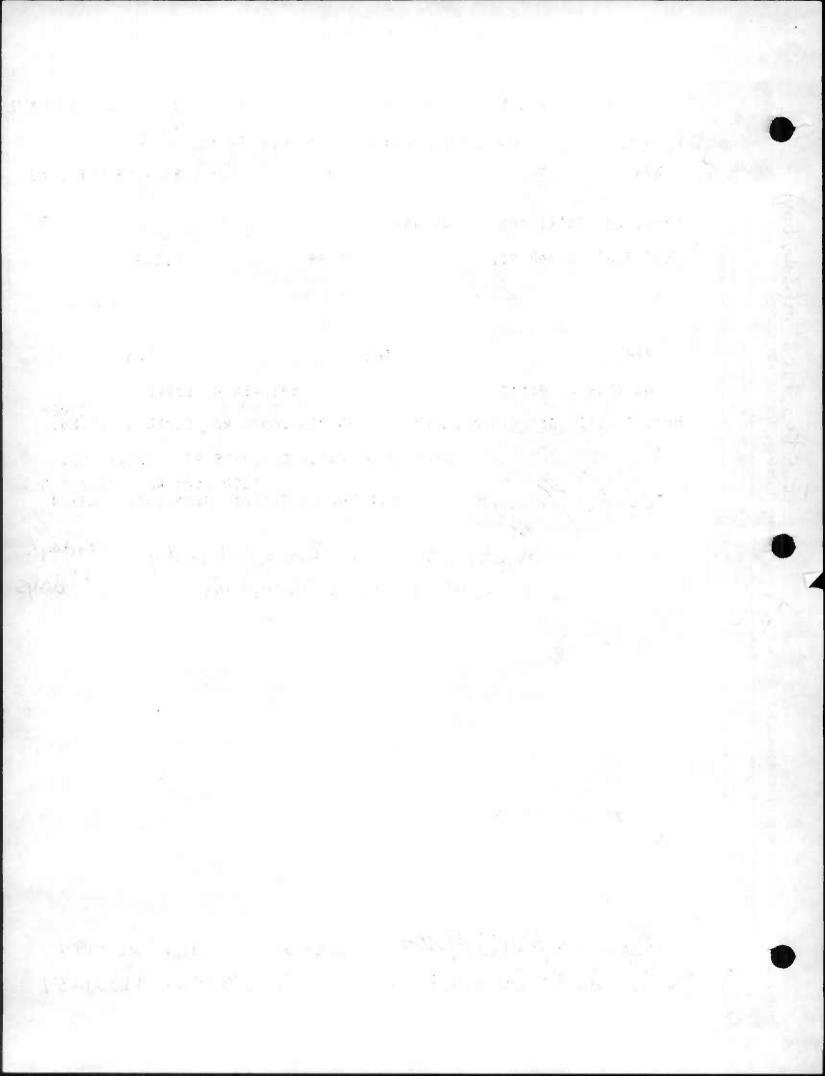
29b. Signeture end title of cartified linda 29c. License number 13831

29d. Date signed (Month, Day, Year) Horil 26, 1998

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD 2123 lelinda 31. Dete tiled (Month, Dey, Year) APR 27 1998 32. Registrar's Signeture

State Registrar who Didson Produce



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Physician Evelyn Carole Bozman 24, APRIL 1998 1:01P.M. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey. Yeer)
July 23, 1944

Baltimore, Md. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 LF Days Months Yrs. 53 219-42-1623 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits re 23e or 28e-f shortment be notified at 1 ☐ Yas 2 No Directo Maryland Baltimore Co. Monkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 15509 Manor Road 21111-2413 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. r than "natural", or flems the Medical Examiner m Was Dacedant Ever in U,S. Armed Forces? 11. Marital Status should be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or item 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Corporate Officer 08 Crane Equipment n/a 18. Mothar's Name (First, Middle, Meidan Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hyant: If itsm 27 is marked oth William Earl Bozman Evelyn Helen Mullan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Louise Meledin (Att./Per.Rep) 406 Bosley Ave. Towson, Maryland 21204-4401 20b. Place of Disposition (Name of cematery, crametory or other place) 20c. Location - City or Town, Stata Dete 20e. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/98 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 22. Nama and Addrass of FacilitRuck Towson Funeral Home, Inc. 21. Signature of Funeral Sarvice Licanse Teffrey L. Gair 1050 York Road Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting In death) /Medical ACUTE RENAL FAILURE 2 DAYS Examiner Due to (or as a consequence of) Examiner HYPOTENSION Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): GASTROINTESTINAL BLEEDING Physician/Medical Due to (or es e consequance of): 2 987 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ALCOHOLIC HEPATITIS Division of Vital Records, þ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed CANCER OF THE BREAST completion of causa of death? page 2 s certificate has 1 Yes X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

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Yas Be 26. Placa of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 2 Athar this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death uneral 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) ã 4 Homicida ò 24 hours Funeral edical 29a. Certifier 🔣 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. (Check only To the within 2 To the 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 4-24-98 D30263

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30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

FRANCIS KHOO M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Nema (First, Middle, Last) **Physician** BALDOCK 25 1998 APRIL 23:21 HARCLD /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number)
THE JOHNS HOPKINS HOSPITAL **Examiner** BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 6. Sax 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) Birthpleca (State or Foreign Country) **Funeral** Deys 1⊠M 2□F Yrs. 74 April 17 1924 Pennsylvania Director 192-12-8312 Usuel Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with Julyry or other traumatic event, the Medical Examinat must be notified at each. 10e. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√2 No Director Baltimore MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? #1102 USA Funeral 8820 Walther Blvd. 21234 12. Was Dacedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detas: 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decadent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Industrial Engineer Industry 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Cheeseman Baldock Mary 2 Percy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8820 Walther Blvd. Baltimore, MD. 21234 Mrs. Luella Baldock/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 4-27-98 Towson, MD. Hilltop Service Co. 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 21. Signeture of Funerel Servica Licans 1050 York Rd. Towson, MD. 21204 23a. Pert1. Enter the disease, or complications that ceusad tha death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on eech line. Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in death) nemorrhage **Examiner** Due to (or as a consaguance of): Physician/Medical Examiner rupture Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events Due to (or as e consequenca of) Lyears abdominal doltic Due to (or es e consequenca of): resulting in deeth) Lest Division of Vital Records, P.O. Box 915 23b. Did tobacco use contribute to the cause of death? Pert II. Other atgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by d 1 Yas 2 No 3 Probably 4 Unknown (0/07 Cancer þ The law requires 24b. Were autopsy findings availebla prior to completion of ceuse of deeth? s need should 24a. Wes en eutopsy performed? Completed hea 1 ☐ Yes 2 No 1 ☐ Yes 20 No certificate or Attending Physicians 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28d. Describe how injury occurred 27. Menner of Deeth 28b. Tima of 28c. Injury et Work? Certification: 5 Panding Investigation 1 MNeturel 1 ☐ Yes 2 ☐ No death. Diractor: / 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) a Funeral Dirac e Funeral Dirac etely filled in by 4 Homicide Medical 29a. Certifie 1 💆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. To the To the To the 29b. Signatura and title of certifiar 29c. Licanse number 29d. Date signed (Month, Dev. Year) APRIL 25, 1998

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12. Registrar's Signeture

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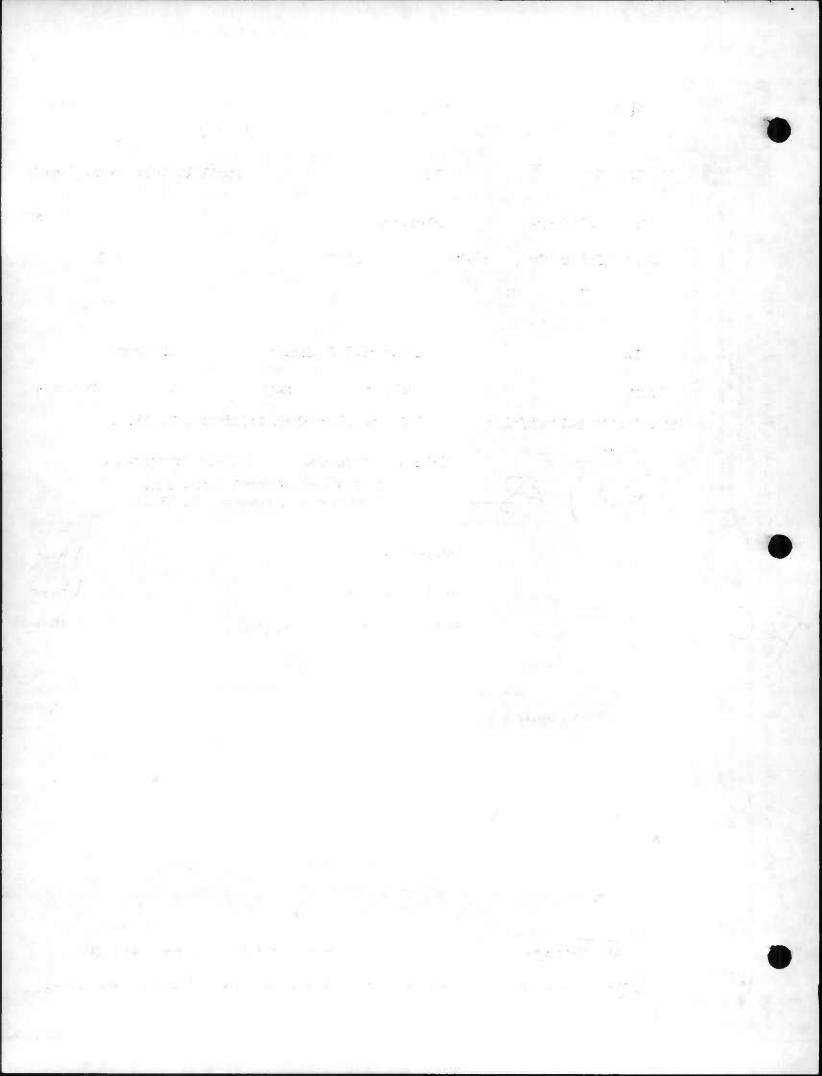
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30. Neme end eddress of person who completed cause of death_(Item 23e) (Type, Print)

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DORAY

31. Data filed (Month, Dey, Yaer) APR 27 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death ; +0 Month **Physician** Russ 0 ADT: 930 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 0/409519 NONSINS 140 cmP Lorien 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sax **Funeral X** M 2□ F Months Deys Hours Yrs. 079-20-6313 70 Director Dec 25, 1927 New York Usual Residence of Decedent the Marylend 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified as New York Oueens Howard Beach 1 XYas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 81-09 156th Avenue 11414 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter v Department of Heelth and Mental Hygiene. Introcrant: If Item 27 is merked other than "natural", or iter any Injury or other traumatic event. XXYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas XXNo Specify: Specify: p XXWidowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Eiementery/Secondary (0-12)
Grade 12 College (1-4or 5+) Grade Building Inspector City of New York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Leonardo Busso Frances Lapigna 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leonard Busso son 4401 Cross Country Drive Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr. 27 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3√ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn Memorial Park 1998 Pinelawn, New York 21. Signatura of Funerel Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Md. 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** head and Neck careinoun 9 /Medical immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician end buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buriel Box 68760. certificate be Physician/Medical Due to (or as a consaquance of): 98 980 ed by the etter deteched for u Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco uea contributa to the causa of death? P.O. signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were eutopsy findings available prior to 24a. Was en autopsy performed? Completed peen completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Morith, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 ANatural 5 Pending 1 □ Yes 2 □ No Investigation 2 Accident ral Director: 6 Could not be determined 3 Suicida 28f. Locetion (Streat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 🗠 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person 1805 Hickory Ridge Rd (Jumsia Md 21044)
32. Aggistrate Signature Randolle pleted cause of death (Item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: item #5 Per FH Film G758 4-27-98RC Certificate of Death Reg. No 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 20 M PW **Physician** .40 4a Facility Nama (If not institution, giva straet and number) BRADSHAW. APRIL /Medical 4b. City. Town, or Location of Daath 4c. County of Death Examiner Northwest Medical Center Randallstown Baltimore If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Min. 1⊠M 2□ F Months Days Hours Yrs. 235 81 Director Oct 21, 1916 AK Usual Rasidance of Dacedant the Marylend 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 215 Nicodemus Rd. 21136 Funerai 14. Race - Amarican Indian, 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 2 should be filed within 72 hours efter ond Mental Hygiene. Is marked other than "natural", or ite 1 X Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: à white 3 X Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) military Sgt Major in U.S. Army 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Wesley Bradshaw Ozie Martin 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) permit. Pages 1 and 2 Department of Health e Important: If them 27 is 27 Wooden Bridge Ct., Reisterstown, MD 21136 Darlene Schapiro - daughter 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burlal 2 【Cramation 3 ☐ Ramoval from Stata injury or Carroll Cremation Service 4/21/98 Hampstead, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funoral Se 22. Nama and Addrass of Facility 11824 Reisterstown Rd à Eline Funeral Home Reisterstown, MD 21136 complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, only one cause on each line. Approximata Intarvai Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaesa or condition resulting in deeth) ADENO CARCINOMA 08 6 MONTHS Examiner Due to (or as a consequence of). Examiner KENAL CARCINIMA physician end the buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequanca of) ASGTIS. Physician/Medical Dua to (or as a consaquanca of): 980 Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a 3 Probably 4 Unknown 1 Yes 2 No OBSTRUCTIVE PULMONARY DISEASE by Division of Vital Records, 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed CORUMBRY PRIERY DISEASE completion of causa of daath? 25 No 1 ☐ Yas 2 ☐ No certificate 25. Wes case referred to medical axeminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 2 1 Yas 25 No 191 inpatiant 2 ER/Outpatient 3 DOA 죑 Certification: 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? Attanding. 5 Panding invastigation 1 Naturel or Attending after death. 1 Yes 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of fnjury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 - Homicida

2 William 2

Registrat

Medical

29a. Cartifiar

(Check only one)

29b. Signatura and titia of cartifian

JOGINDER

multa mo

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

29d. Data signed (Month, Day, Year) 29c. Licansa number

1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date end plece, end due to tha causa(s) and menner as stated.

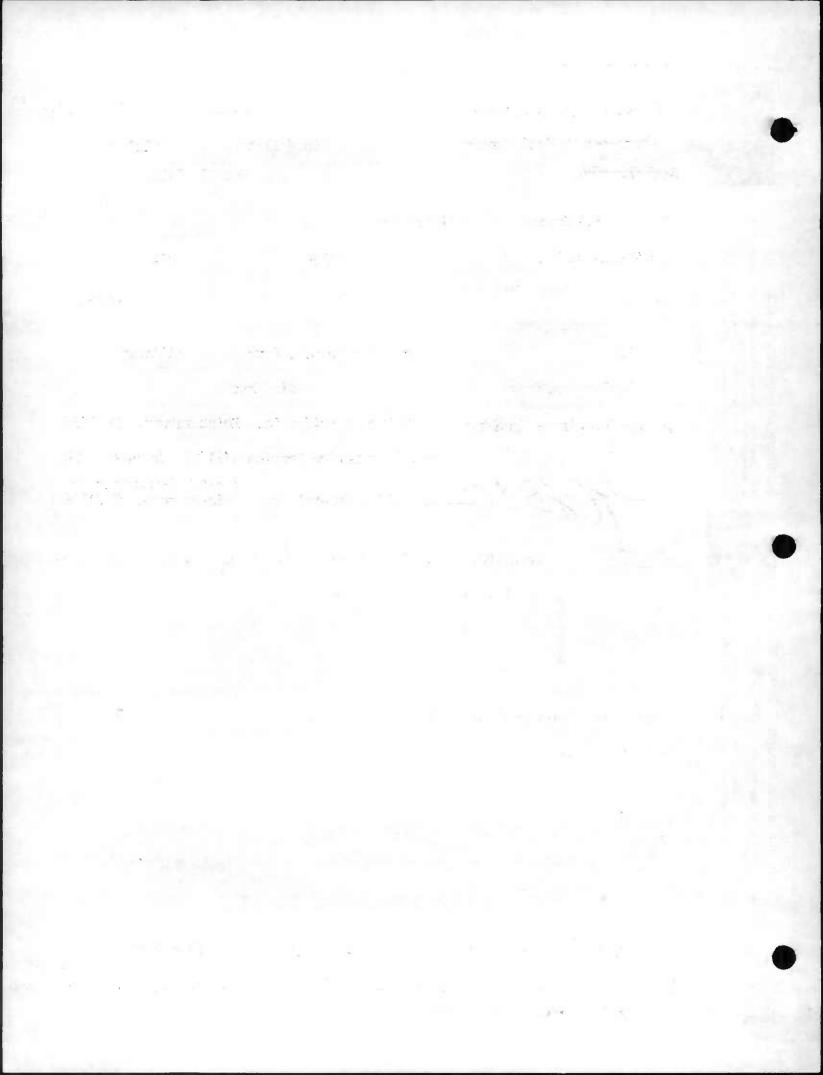
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and dua to the causa(s) and manner stated.

MEHTA, M.D. NURTHWEST HISPITAL

32. Régistrar's Signatura Jondon

D41410

21133. CENTER RANDAUSTUWN MO



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Ł	lima	2	0	O

1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** April 17,1998 4:30 p.m. Carpeneto Irene /Medical 4b. City. Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick 8. Dete of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country) Ireland 7. Age (In yrs. lest birthdey) **Funeral** Deys Hours 1 M 2 KF 215-26-1496 Yrs. Director Usuel Residence of Decedent deeth with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits **ahow** 7 is marked other than "natural", or items 23a or 28a-f abov traumatic avant, the Mod cal Examiner must be notified as Maryland Frederick 1 ☐ Yes 2 ☑ No Director Frederick 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 1001 Wilson Place 21702 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after d. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or them any Injury or other traumatic avant, the Mental Process 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Proof Reader Newspaper 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Patrick Joseph McPartlin Mary Murray 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2205 Banner Hill Road, Frederick, Maryland 21702 Patricia Grumbine/daughter 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signeture of Furnadal Service Licental S. V. 22. Name and Address of Fecility Director Wade State Anatomy Board, 655 W. Baltimore Street nous week Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical fmmediete Ceuse (Finel BREAST CANCER, METASTATIC 6 YRS diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of) attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Denpatient 2 ER/Outpetient 3 DOA Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide

State Registrar

Medical

DONELSON M 31. Dete filed (Mont Day Year)

Donela

29b. Signeture end title of certifier

29a. Certifier

TOLLHOUSE #203 915 32. Begistrer's Signeture

Andele

Andele

Mo

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

1 Cartifying Physicfan: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

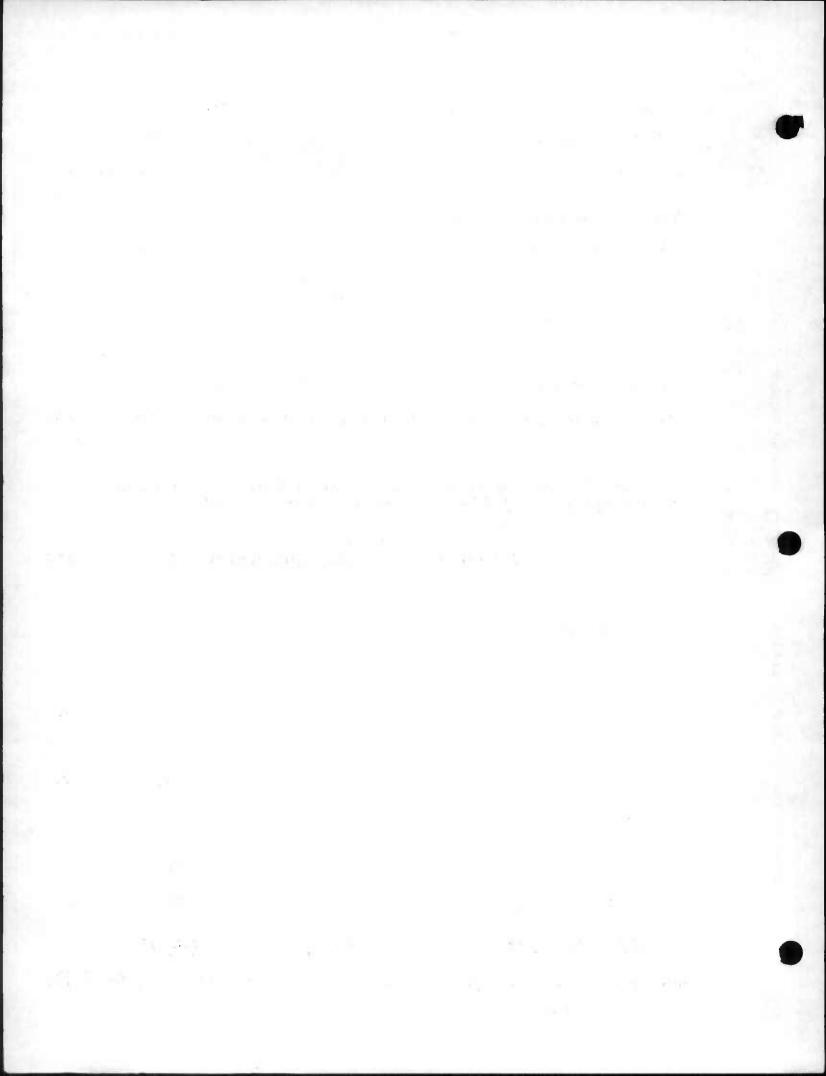
2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated.

29c. License number

021936

29d. Date signed (Month, Dey, Year)

FREDERICE, MO Z1701



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth Month 0420 BROWDA 8 COTTER 22 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) University of MANJEMES M-DICOR 54 STEWN BALTIMONE 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 M 20 F 218-46-6677 52 Yrs am Usuel Residence of Decedent 10e. Stete 10b. County City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA WD MORE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 3803 21215 Jabash Ale USA 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Stetus 1 Yes 2 Who
If Yes, Give
Year or Detes: 1 □ Never Married 2 □ Merried 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 18e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ACA 12th 221210V 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) HildaTowns M, 1400 EDDES 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3803 Wabash Ave. Apt 28 Dalto JEFFREY COTTEE-20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) FOREST 5-4-98 WING Mill. GARRISON 22 Name and Address of Fecility
WMC. March
4300 Wabash 21. Signature of Funerel Service Licenses Home Wast, INC Descal Dalto 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and or heart biliure. List only one cause on each line. Onset end Deeth Immediate Cause (Final disease or condition resulting in death) CARDIAC FAILUR Due to (or es e consequence of) Sysnus OGPOS FAILURE MULTIPLE Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of) Consumy ARTENY DISMEST THROMBUS CALDIAR Due to (or es e consequence of) resulting In deeth) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Pres 2 No 3 Probably 4 Unknown TOBACOU 24b. Were autopsy tindings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Fres 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner?

1 Yes 2 Yo 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manper of Deeth 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? 5 Pending investigation 1 Natural

/Medical Examiner ettanding physician the 98 use hes this funeral

Examiner Physician/Medical þ Completed P Certification:

Physician

/Medical

Examiner

Director

Funeral

À

Completed

Funeral

Director

T is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at

hours after

permit. Peges 1 end 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neement in Jury or other traumatic."

Physician

Saltimore, Maryland 21215-0020

Division of Vital Records.

To the I within 2

or Attanding efter death. Hospital c 24 hours e

(Check only one) 29b. Signature and title of certific

T

2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier

6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyaictan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

D44498

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) BORCHELT

22 S. GREENE

ST

BATTIMORE, MD 21201

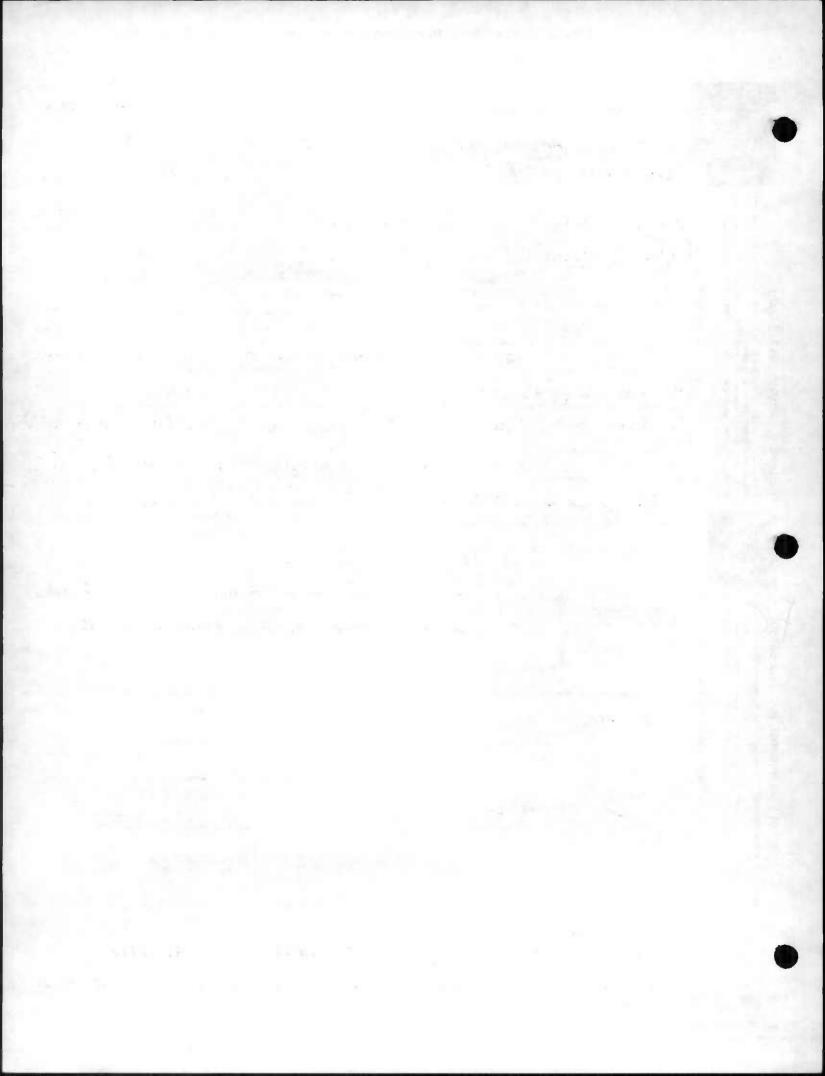
State Registrar

Medical

32. Registrer's Signeture

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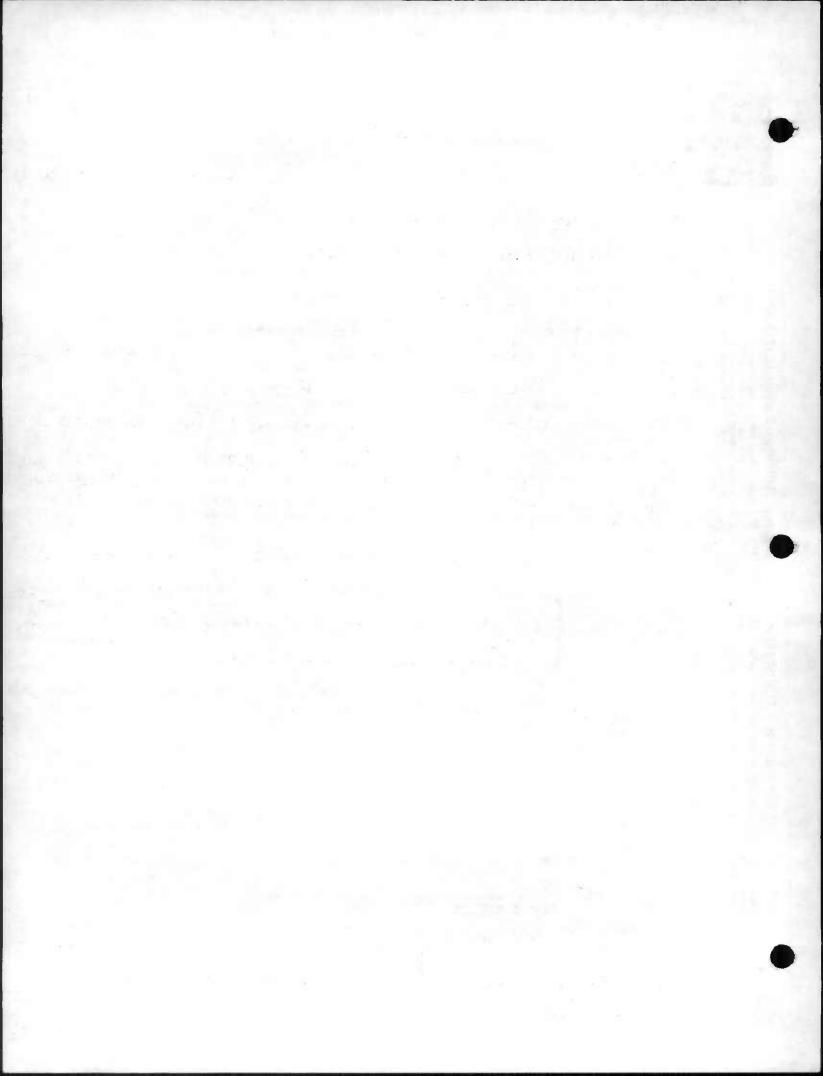


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) COLE **Physician** PM 21 JAMES /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE SECOURS 30N AM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 19M 2□ F 218-05-386 Director Usual Residence of Decedent d 2 should be filed within 72 hours efter death with the Marylend th and Mentel Hygiene.
7 Is marked other than "naturel", or items 23a or 28e-f ahow traumatic avent, fre Aedicial Example must be notified. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 1 Yes 2 No Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4641 Manordene Rd. Apt. A 21229 AZU Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 7 . 13-47 1 Yes 2 No Specify: Black by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Jantor U.S. GOVERNMENT NA NOTA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be fi Department of Heelth end Mentel I Important: If Itam 27 is marked of any Injury or other traumatic aver Montague James E5510 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4641 Manordene ed Apt. A Dalto md. 21229 Mary Cole 20b. Place of Disposition (Neme of commetey, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State SUPPLISON TOREST VET. -27-98 OWINGS Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERa Home West Aug. 4300 Wabash 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ten Su Disi Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the ceuse of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? should should Completed 24a. Was an autopsy page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate al or Attending Physician: T s efter deeth. I Director: After this certificat funeral director. Be 25. Was cese referred to medical 28. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours eff To the Funerel DI completely filled in 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month. Dev. Year) 29b. Signature and title of certifier LORI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROS(TAK, CRUZ M-5) BON SECOURS

State Registrar 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 12989 BARBARA CANN

Physician /Medical Examiner

Funeral

Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 le marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Eranical must be notified at once. Baltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

been signed by the attanding physician and should be datached for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2:

Completed by Physician/Medical Examiner

Be

Certification: To

Medicai

29a. Cartifiar

Item: 23 part Items: 23 part I,27	I, per MEO G-	G-762 8/5 759 5/20/	798 reb 98 Ger	tificate	of	Death			Reg. I	No.	1 (
1. Decedant's Name (First, Middle	i, Lest)							2. Data of De				3. Time of Death
BARBARA CAI	NN							Month APRIL		о _{ву} 20,19	Year 9.8	1:00P.M.
4a Fecility Nema (If not institution	, give street and nu	ımber)				4b. City, To		cation of Deat		4c. County		100000000000000000000000000000000000000
2202 ROUND ROAD	APT B-4	1				BALT		E		N/A	1	
5. Sociel Security Number	6. Sax	7. Age (In yrs. i		If Undar 1 Months	Yaar Days	If Undar Hours	24 Hrs. Min.	8. Date of Bi	rth av. Yea	ar)	9. Birth	placa (Stata or Foreign
215-40-8159	1□M 2X)F	54	Yrs.		- 117			July	15,	1943	Ne	
Usual Rasidanca of Dacedant												
10e. Sfata 10b. County		10c. City	y, Town or Lo	cation								10d. Insida City Limits
Maryland I	N/A	Ва	ltimo	re								Yas 2□No
10e. Street end Number				10f. Zip C	oda				10g.	Citizan of \	What Cou	intry?
2202 Round Ro	nad Ant	B-4		21	22	5		110	T	I.S.A		
11. Marifal Stetus	12. Wes Dec	edent Evar in U.	S. 13. V	Vas Deceda	nt of h	lispenic Ori	gin? (Sp	ecify Yas or No Rican, atc.)		14. Rac		icen Indien,
1 ☐ Nevar Married 2 ☐ Marri	Armed Fo						i, Puarto	Rican, atc.)			ck, White	
3 Widowed 4 Divorced	If Yas, Gi	va	1	☐ Yas 2	XI No	Specify:				Specify	y: B1	ack
15. Decedant	's Education		18a. Deced	ant's Usual	Occup	ation			16b.	Kind of B	usinass/l	ndustry
(Spacify only highes	1		(Giva	kind of work	done	during mos d)	t of work	ing	Ba	ltim	ore	City
Elamantary/Secondary (0-12)	1-4or 5+)	(Clet	2	K			Police Departmen				
17. Fether's Nama (First, Middla,	Last)					18. Moths	r's Nam	a (First, Middle	, Maid	lan Suman	na)	
Joseph Cannad	1.77					Mox	D	0++0**				
19a. Informant's Name/Ralationsl			19h Mallin	n Addrass /	Straat	and Number	y P	atter:	S O III	v or Town	State 7	ip Code) 21060
Pamela Dotson			7816	Dol+	i m	2 2 2	Λ	napol:	. ~	D 1 al	0.1	21060
20a. Mathod of Disposition	1	20h P	lace of Dispos			ore a	AII	napor.	-			en Burnie Town, State
1 Burial 2 X Crametion	3 Remova from	State C	ematary, cran	natory or oth	ar pla		1,	10510				
4 Denation 5 Other (Sp		Met	ro Cr	emate	ory	<i>T</i>	14	/25/98	3 B	alto	. M	D
21. Signature of Funeral Service	logisee	lone	Ma Ma	Nama and	Addra	W . J	one	s,Jr 1	Tun	eral	Но	me P.A. , MD 2122
connec	aarro	1-	41	.01 E	dmc	ondso	n A	vénue	Ba	ltim	ore	
23a. Part1. Enfar tha disaasa, or shock, or haart failura. List	complications that only one cause of	ausad tha daati	RDIAC AF	RRHYTHM	of dyi	ng, such as DUE TO	PULM(or raspiratory a	ERTE	ENSION	1	Approximata Intarval Batween Onsat and Death
Immediata Causa (Final	V	AN	D RIGHT	VENTRI	CUL	AR HYPE	RTROF	ΉΥ				
diseasa or condition rasulting in death)	e. CARDIA	C ARRHYTH	MIA DUE	TO CON	GEN:	HAL CA	RDIAC	ANOMALY				
Tabaling III additiy		Dua to (o	r as a conseq	uance of):								
	IDIOF	ATHIC PUL	MONARY F	IBROSI	S							
Sequentially list conditions,		Dua to (o	r as a consaq	uance of):								
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury												
that initiated avants rasulting in daath) Last	С.	Due to (or	r as a consaqu	uanca of):							1	
The same of the sa											- 1	
	d											
Part ii. Other significant conditio	ns contributing to d	laath but not rasi	ulting In the ur	ndarlying car	usa gi	van in Part I	l.	23b. Dio	tobac	co use co	ntribute	to the cause of death?
								1	Yes	2□ No	3 □ Pr	obably 42 Unknown

24b. Wara autopsy findings available prior to

24a. Was an autopsy performed? 1 Yas 2 □ No

completion of cause of death? 1 Yas 2 No

25. Was case rafarred to medical axaminar?

1√□ Yas 2□ No Hospital: 27. Mannar of Death

26. Placa of Daath (Check only ona) Othar: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA 28b. Time of 28d. Dascribe how Injury occurred

1 KNatural 5 Panding invastigation 2 Accidant 6 Could not be 3 ☐ Suicida 4 Homicida

28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Yas 2 No 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

(Check only one) 29b. Signatura and titla of certifiar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signad (Month, Day, Year)

O.C.M.E.

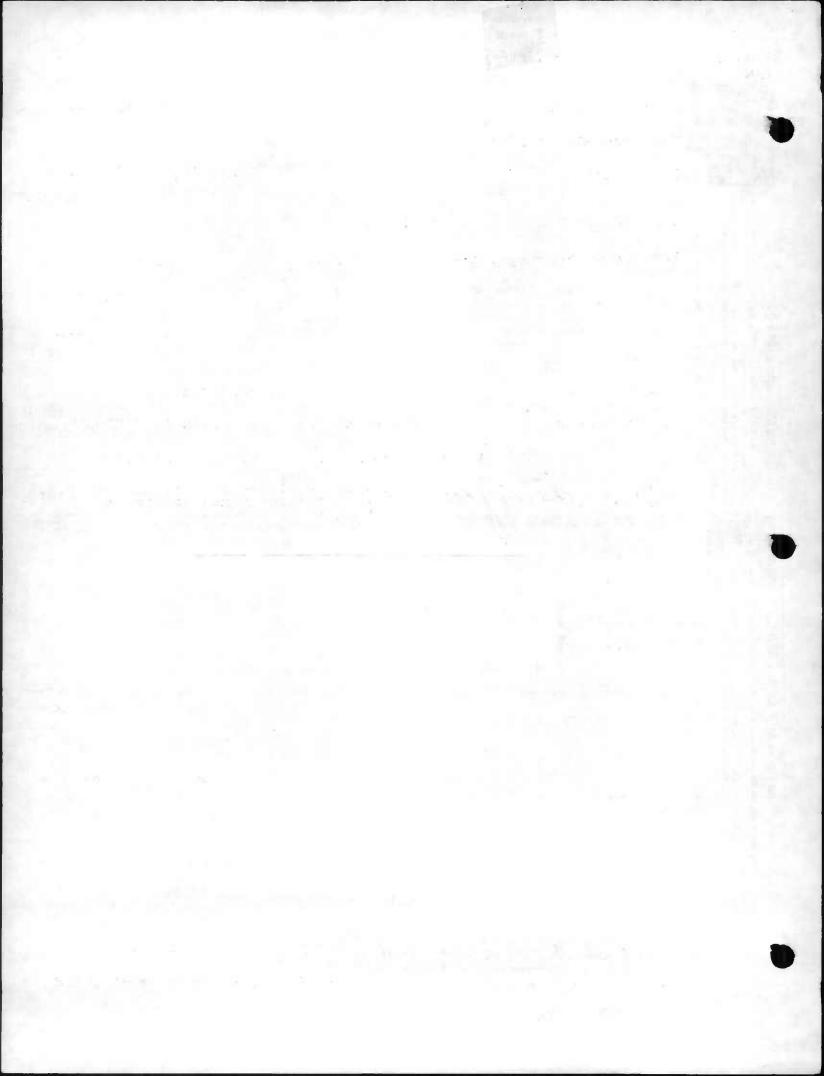
APRIL 21,1998

30. Name and address of person who complated causa of death (fam 23a) (Type, Print)

Radentz 5 phen 31. Data filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Ragistrar's Signatura ruha Davidson-Mandalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 8:18 P.M. April 1998 William George Canning County of Deeth 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) SQUARE 6. Sex OSEDA If Under 24 Hrs. Hospila FRANKlin CenTek 10 MORE 5. Sociel Security Number 7. Age (# Birthplece (Stete or Foreign Country) (In yrs. last birthday, 8. Dete of Birth (Month, Dev. Year) 1 ☑ M 2 ☐ F Deys Months Hours 219-16-8621 April 12, 1925 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City. Town or Location MD 1 ☐ Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3908 Walnut Avenue 21206 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ™ Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engeneer Telephone Company 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) George Leo Canning Mary Jane Ware 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Perry Canning 4205 Fullerton Avenue Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) New Cathedral Cemetery 20a. Method of Disposition 20c. Location - City or Town, State t Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4/27/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name end Address of Fecility Dippel Funeral Home Inc. 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximately a shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) 60 days Preumonia obstructive pulmonary disease Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 22 No 1 ☐ Yes 2 No 1 Yes 25. Was cese referred to medicel exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Netural 5 Pending 1□ Yes 2□No investigetion 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Department of Health a important: if Item 27 is any injury or other trak **Physician** /Medical Examiner Examiner Division of Vital Records, P.O. Box 68760. Physician/Medical physici the certificate 88 requires that the deeth the signed by the þ Completed peen hes The certificate or Attending Physician: director Be 10 After this funeral dir Certification: death. 24 hours efter death filled in by edicai completely within 2

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Examinar must be notified at

and Mentel Hygiene.

Pages 1 and 2 should be

with the Maryland

Annin

04

Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen Selinger M.D. 900 Selinger Stephen

4 Homicide

(Check only one)

29b. Signeture end title of bertifier

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

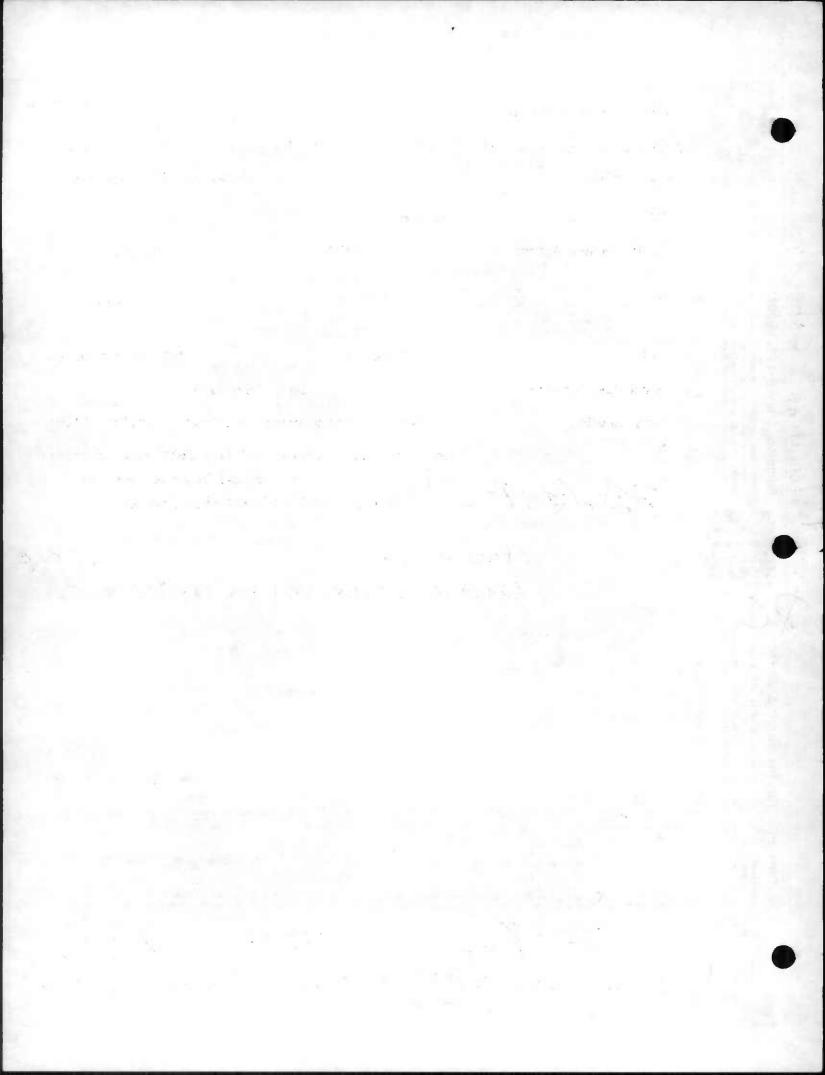
| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 29d. Date signed (Month, Day, Year)

9000 Franklin Square Drive Baltimore, Md.

31. Dete filed (Month, Dey, Year) APR 27

Henry

32 Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Gertificate of Death

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	5. Social Security N 217-20-03	lumber 6. S			lest birthdey) Yrs.	If Under 1 Yes Months Dey		Min.	8. Dete of Bir (Month, De Sept.	th ey, Year) 8,1908		place (State or I	Foreign
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Director	10e. Stete Maryland	10b. County Anne Al	rundel		y, Town or Loc en Burn							10d. Inside City 1 ☐ Yes 2	
	10e. Street end Nur		Lanaci		J	10f. Zip Code				10g. Citizen of	What Cou	ntn/?	
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	1648 Furi	nace Driv	12. Wes Deced	ent Ever in U	S. 13. V			rlain? (Spe	cify Yes or No			can Indien,	
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	20e. Method of Disposition 1 ፟፟፟ Buyrial 2 □ Cremetion 3 □ Removel from State				cemetery, crem	sition (Neme of natory or other p	olece)	Apr	il 24	20c. Location			
	4 Donetion	5 ☐Other (Special	(b)	Gl		en Mem.			998	Glen Bu	urnie	, Maryl	land
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	1/30	10/10	LL		42	21 Crain	n Hwy.	, S.E	., Gle	n Burnie	e, MD	21061	
	23a. Pert1. Enter the shock, or hear	he disease, or com rt failure. List only	nplications thet cau	used the deet ch line.	h. Do not ente	er the mode of d	lying, such es	s cardiac o	or respiratory a	arrest,		Approximete Intervel Between	een
			6	7		11-	. +	1	T 0	*	i	Onset end De	eath
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	resulting in death)		P		or es e conseq	uence of):	4				1	, 0	/
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	Pert II. Other signif	leter	Melli		rading in the ur	idenying cause	Angul in Lett	ξ I.		Yes 20 No		obably 4 U	
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	2 ☐ Accident 3 ☐ Suicide	6 Could not b	28e. Piece o	f Injury - At h	ome, farm. str	eet, fectory, offic				(Street end Num	ber or Ru	rel Route Numb	er,
	4 🗌 Homicide	Oetermine0	bullding	, etc. (Specif	fy)					wn, Stete)			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** Year ROBERT DECKER April 23, 1998 8:10 am /Medical 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year 5 Social Security Number 6 Sev If Undar 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months ty□ M 2□ F Days Hours Yrs Director 161-03-8479 11-15-1911 Pennsylvania Usual Residence of Deceden with the Maryland 10a Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2 No Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 234 Linden Ave. 21286 U.S.A. death v Funeral Was Decadent of Hispenic Origin? (Specity Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11 Marital Status Was Decadent Evar in U,S. Armed Forces? filed within 72 hours after 1 ☐ Yas 2 💢 No If Yes, Give 1 Naver Married 3 Married 5 Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor-Foreman Martin Marietta Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health end Mental H lant; If Item 27 Is marked oth Be 0 traumatic Effie May Kingel James Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health el Important: If Item 27 Is any Injury or other trai Mrs Clara C. Decker (Wife) 234 Linden Ave., Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 Burlal 2 Cremetion 3 Removal from State Dulaney Valley Mem. Gards. 4-27-98 Timonium, Maryland 4 Donetion 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S Brooks 1050 York Road, Towson, Md. 21204 0 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Prostate Cancer **Examiner** Due to (or as a consequenca of): Failure Rena1 Saquentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760, Physician/Medical ading phys pu Due to (or as a consequence of): The law requires that the death certificate P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 3 ☐ Unknown of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy narformed' completion of cause of death? certificate 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Mother (Specify) HOSPICE 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28c. Injury et Work? Certification: 28b. Tima of 28d. Describe how injury occurred After Attanding Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not ba 3 ☐ Sulcida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a, Certifier (Check only one) êg. d title of certifie 29b. Signature 29c. License number 29d. Date signad (Month, Dey, Year) Venods 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Skha Davidson Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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al	5. Sociel Security Number 214–12–8372	6. Sax 1 M 2 F	Aga (In yrs. I	ast birthday) Yrs.	If Undar 1 Yaa Months Deys		4 Hrs. 8. D Min. (//	ata of Birth Month, Dey	1917	9. Birthpi Coun Mary	leca (State or Foraig trx) Land	
_	Usuel Residence of Decedent 10a. Stete 10b. County Md. Baltis		10c. City, Town or Location Pikesville								0d. Inside City Limits	
Directo	10e. Street and Number 312 Upla		10f. Zip Code 21208					1	10g. Citizen of V	What Coun	try?	
by Funeral Director	11. Marital Stetus 1 Never Merriad 2 Marri 3 Widowed 4 Divorced	12. Wes Decede Armed Force	s?] No	t Evar In U,S. 13. Was Decedant of His If Yes, specify Cuben			Hispanic Origin? (Specify Yes or No- ben, Mexicen, Puerto Rican, etc.)					
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	19e. Informent's Neme/Reletions				Address (Street						Code)	
	Joan R. Sherman 20a. Method of Disposition 1 M Burial 2 Cramation 3 Removal from Stata 4 Donetion 5 Other (Spacify)			20 Tommy True Ct., Par 20b. Place of Disposition (Name of cemetery, cremetory or other place) Mt. Olivet Cem., April 29,				ite	20c. Location -	City or To		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Physician Henry B. Dorshow 25 1998 10:55 AM /Medical APRIL 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Agnes Hospital Baltimore City if Undar 1 Year If Under 24 Hrs. 8. Deta of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** tv M 2□ F Vrs Director 477-30-4979 62 April 3, 1936 Minnisota Usuel Rasidance of Dacedant the Meryland 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Modical Examinar must be notified at 10d. Insida City Limits 1 Yas 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 1820 Frederick Road 21228 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 11. Marital Status filed within 72 hours efter Hygiene. 1XXYes 2 □ No If Yas, Giva Yeer or Datas: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highest greda complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Years Years Financial Anylist Brokerage Company permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 Is marked othe any Injury or other treumatic event once. 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumama) 89 Jack Dorshow Sally Unknown 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1820 Frederick Road Mrs. Alice Dorshow Catonsville, MD 21228 20b. Placa of Disposition (Name of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4/26/98 Baltimore Washington Crematory 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Neme end Address of Fecility Sterling Ashton Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD van collecting disaasa, or complications that ceusad tha daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the of feiture. List only one cause on each line. Approximata Intervel Between Onset end Death Physician /Medical Immediata Causa (Final disaesa or condition resulting in daath) Myscardie years **Examiner** Examiner Sequantially list conditions, if eny, leading to immadiate cause. Entar Undarlying Ceuse (Disease or injury NAME: Henry Dorshow Division of Vital Records, P.O. Box 68760 Physician/Medical thet initiated events resulting in death) Last ettending physi the Due to (or as a consequence of) 98 esn Part II. Other aignificant conditions contributing to death but not rasulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed hes certificate 2 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 27. Manner of Death I Director: After the Certification: 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding investigation deeth. 1 Yas 2 No 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Placa of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledga, daath occurred at tha time, date end placa, and due to the cause(s) and menner as steted.

[2 Medicat Examiner: On tha bests of axamination end/or invastigetion, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and menner steted. Medical (Check only one) 29b. Signatura end title of cartifiar 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and addrass of person who complated cause of death (Item 23e) (Type, Print)

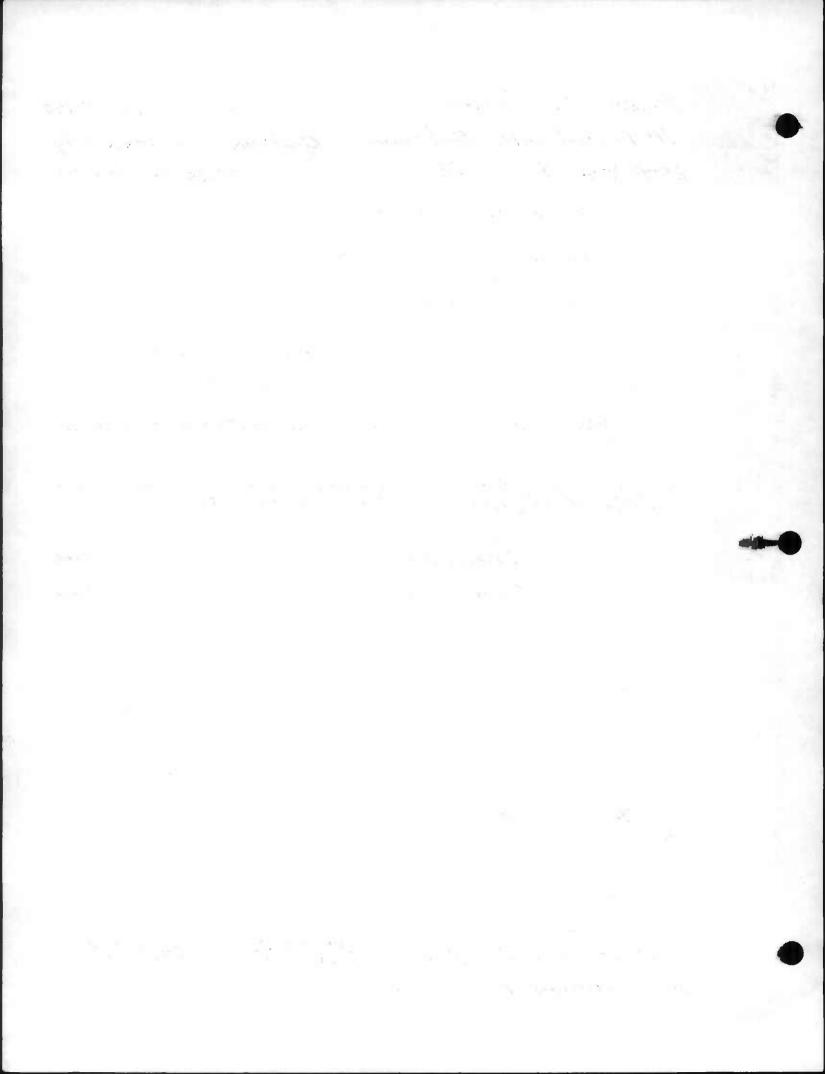
Michael Silverman, MD Sant Agnes Hospital Baltimore, MD 21229

32. Registrar's Signatura

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			,	(Certifica	ate of L	Death		Reg. No.	5 12	995
Physic /Med		1. Decedent's Name (First, Middle, Last	Fleenor					2. Date of Dec Month	Dey	Year	3. Time of Earth
Exami		4a. Fecility Name (If not institution, give	street end number) Con few 131	c/+	unore	4	4 / 1	Location of Deeth		of Deeth	City
Funeral Director		7/3 /0 /076 /	X 7. Age (In yrs.	9	rs. if Und Month	der 1 Year ns Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h y, <i>Year</i>)		e (Stet or Foreign
Maryland of show	tor	Usual Residence of Decadent 10e. Stete 10b. County Maryland Baltimo			or Location imore						Inside City Limits 1 ☑ Yes 2 ☐ No
th with the 23e or 28e	Funeral Director	10e. Street end Number 130 North Lindwoo	od Avenue			Zip Code			10g. Citizen of V	What Country?	,
72 hours after death with the Maryland natural, or Items 23a or 28a-f show lical Examiner must be notified at	by	11. Marital Stetus 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Detes: 1952			cedent of Hi pecify Cubar 2 □ No	spenIc Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		a - American I ok, White, etc.	
within son.	Completed	15. Decadent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation	16a. [sual Occupa work done d use retired, Techn	uring most of wo	rking	16b. Kind of Bu		ry
of 2 should be lifed the and Mental Hygin Tris marked other traumatic event, it	To Be Co	17. Fether's Name (First, Middle, Last) Joseph Goodman		1	11000	Toomi		me (First, Middle, Fleenor			
2 sho and h	-	19e. Informant's Name/Relationship (T)	rpe, Print)	19b.	Mailing Addre	ess (Street e	nd Number or R	urel Route Numbe	er, City or Town,	State, Zip Co	de)
ges 1 ar t of Hea if Item 2 or other		Brenda Foltz/si 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. I	Place of I	8 Ches Disposition (A cremetory o	Vame of		Date	ver, Pen 20c. Location -		nial7331 State
pemit. Pa Department Important: any injury once.		21. Signature of Funeral Service Licens Ronald S. Wa	de Director					rd, 655 and 21201	W. Balti	imore S	Street
hysician	1	1 Intl. Enter the disease, or complete cock, or heart failure. List only or	icetions that caused the dear ne ceuse on each line.	th. Do no					rest,	inte	proximate erval Between aset end Death
/Medical Examiner	5	Immediate Ceuse (Finel disease or condition resulting in deeth)			onsequence o	of):				10	years
rificate be executed ng physician and es the buriel-transit	cal Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	· .		onsequence o					2	'years
death certificat e attending phy of for use es th	Physician/Medical	resulting In death) Lest) es a co	- Isoquence o					1	
Z 0 D	/sici	Part II. Other algnificent conditiona cor	tributing to death but not res	sulting in t	the underlying	g cause give	n in Pert I.	23b. Did t	obacco uae cor	ntribute to the	e cause of deeth'
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The law requires that the law been signed by the page 2 should be detached.	Completed				1			24e. Was perfo	en eutopsy rmed?	evailat	eutopsy findings ble prior to etion of cause th?
	0	25. Was case referred to medical					26 Place of Do	1 ☐ Y	- /	1 🗆 Ye	es 2 No
	ToB	examiner?	Iospital:	ER/Outp	patient 3	DOA Othe	p.	dome 5 ☐ Resid		er (Specify)	
Ing Une		27. Menner of Deeth 1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Tir Inj	me of ury M	28c. Injury Work			ow injury occurr		
ftal or Attend us efter death ral Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farr	n, street, fect	ory, office		28f. Location (5 City or Tox	Street end Numb m, State)	er or Rurel Ro	oute Number,
To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b	Medical	one)	elcian: To the best of my knower: On the basis of exemination and manner stated.	wiedge, ation and/	or Investigation	on, in my op	inlon, death occu	urred et the time,	date end place, a	and due to the	ceuse(s)
or vit	M	29b. Signature end title of cardinal	An	ns		P1	1754	<u>'</u>	29d. Date signed $04/2$	Month, Dey	, Yeer)
		30. Name end address of person who co	mpleted cause of death (iter	n 23a) (T	ype, Print)	dica	1 C+	8.			
Sta	ite	31. Dete filed (Month, Day, Year)	32. Registrar's Signa	ature	Randal	0_					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death APPLIL Z Year Year Ac. County of Death FERRO WILLIAM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Carroll County Gen. Hospital Carroll Westminster 9. Birthplace (State or Foreign 1904 Virginia If Under 1 Year | if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1□**X**M 2□ F Months Days Hours Min 578-01-4465 93 Yrs. Usuai Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits Md_ Baltimore Owings Mills 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 43 S. Ritters Lane 21117 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, 11, Marital Status Bleck, Whife, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilega (1-4or 5+) Md. Dry Dock 12 Ship Fitter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Philomena Dinori Antonio Ferro 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 157 Pittston Circle, Owings Mills, Md. 21117 Frankie Marie Ferro 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park Apr. 29, 1998 Sykesville, Md. 22. Name end Address of Facility 21. Signature of Fynerel Servica Licenses Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haary planta. List only one cause on each line. Approximate interval Batween Onset and Death PNEUMONIA Immediate Cause (Final diseasa or condition resulting in daath) ZWeeks CHRONIC OBSTNUCTURE PULMONANY Due to (or as a consequenca of Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Wes en eutopsy performed'

Physician /Medicai Examiner

Important: If it any injury or c

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

r than "natural", or items 23a or the Medical Examiner must be

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be finent of Health and Mental Hint: If item 27 is merked ot

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box

or Attending a stor death.

To the Hor within 24 h To the Fur completely

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2770

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last Physician/Medical

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Completed

Be

2

Certification:

Medical

24b. Were autopsy findings eveilable prior to completion of cause of daath? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 5 Pending investigation

1 Inpatient 28a. Date of injury (Month, Day Year) 28b. Time of

-ened

2 ER/Outpatient 3 DOA 28c. injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

29a. Cartifian

Natural

2 Accidant

3 Suicide

4 - Homicida

6 Could not be datermined 28a. Placa of injury - Al home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

2 No

29b. Signatura And fittle of certifier

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

26. Piaca of Daath (Check only one)

Hospital:

ANDOLL COUNTY

State Registrar 31. Date filed (Month, Day, Year) APR 27 32. Registrar's Signature Fichia Davidson-Randalle Education that the letters . The place of the same

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9809903355 UNIT # 16-85-94 FERRO, WILLIAH LEE 160-R BOGDASCHEWSKYI, ALEXA 09/19/1904 H 04/10/98

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: item #24a Per MD Film g758 4-27-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Milliam Balu 20:35 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Baltimore Cattimore, MD 10 welly If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) 12M 20 F **Funeral** Months Days Hours Min. NI A Yrs. 0 Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactinar must be notified as Maryland Baltimore City Baltimore ₩ Yas 2 No Directo 10g. Citizen of What Country? U.S.A. 10e. Street end Number 10f. Zip Code 21215 with 625 North Castle Street permit. Pagas 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is merked other than "natural", or itema 23a
and injury or other traumatic event, the Medical Exercises. Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Paca - American Indian 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grede completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) none none 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Sharpe Gilliam John McFadden 10 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 625 North Castle Street, Baltimore, Maryland 21215 Sharpe Gilliam/mother 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 🕱 Other (Specify) in State 21. Signature of Funeral Service Licensee

Joseph B Van 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore St. Joseph, Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Extreme Prematirity - 18 wh fetus /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Maternal Crowsammientes hysician and the burial-transit cartificata be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Due to (or as a consequence of) use as t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached signed by t 3 Probably 4 Unknown 1 Yes 20 No þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? has page 2 certificate 18 Yes 2 □ No or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 18 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28d. Describe how Injury occurred 28h Time of 28c. Injury et Work? Certification: 28a. Date of Injury (Month, Dev Year) 5 Pending investigation 1. Netural 24 hours after death. Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3∏ Suicide Location (Streat end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated To the within 2 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier #9c. License number

State Registrar 31. Date filed (Month, Dey, Year)

APR 27 1996

Yatel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sicha Davidson-Randalle

Baltimore. MD 21230.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Yaar SR. HELEN GRENDA ENDA April
4b. City, Town, or Location of Daath 22 1998 12:30 P.M. /Medical 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Daath Examiner Catonsville Baltimore Saint Joseph's Nursing Home TOME
7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Yaar) 5. Social Sacurity Number 6. Sax **Funeral** Birthplaca (Stata or Foraign Country) 1□M 2√2 F Yrs. Director 217-58-1984 88 Delaware Usual Rasidanca of Daceden the Meryland 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits 28a-f show Examiner must be notified at Maryland | Baltimore 1 XYas 2 □ No Director Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1220 Tugwell Drive Funeral 21228 USA 12. Was Dacedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status Navar Married 2 Marriad ò 1 ☐ Yas 35 No Spacify: þ Specify: White 3 □ Widowad 4 □ Divorcad "natural", Completed traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacadent's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) filed within 7 Hygiene. Pages 1 end 2 should be filled within tent of Heelth end Mental Hygiene.
https://doi.org/10.1006/10.10 Etementery/Secondery (0-12) Coltege (1-4or 5+) 12th Catholic Nun Religious Order 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Be Anastazy Grenda Mary Lewandowski 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Sisters Servants of Mary 1220 Tugwell Drive Catonsville, Maryland 21228
position (Nama of Data 20c. Location - City or Town, Stata other Immaculate Religious Congregation 1220 Tugwe.
20a. Method of Disposition (Nama of camatary, crematory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Important: Holy Rosary Cemetery 4/25/98 Baltimore Maryland 21. Signature of Funeral Service Lipedsee 22. Nama and Addrass of Facility David J. Weber Funeral Home 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate **Physician** re Hent Inlere
ras a consequence of):
Myocondist Inforce /Medical Immediata Causa (Final disaasa or condition resulting in deeth) Examiner Examiner Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated evants rasulting in daeth) Last Dua to (or as a consequance of) be exec Physician/Medical 2 Dua to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa referred to medical 26. Pleca of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Diversing Homa 5 Rasidance 6 Other (Specify) P 1 Yas 2 No # 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Affin Athending 5 Pending Invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined 3 Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) B 4 Homicida 6 Letifying Physician: To the best of my knowledga, daath occurred at tha tima, deta and placa, and dua to tha causa(s) and mannar as stated.

| Medical Examiner: On the best of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated. edicai 29a. Certifia: (Check only one) 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) April 22, 1998 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) This K 405 Frederick EPPUND C. 27 1998 31. Data file APR State

Registrar

32. Registrar's Signatura

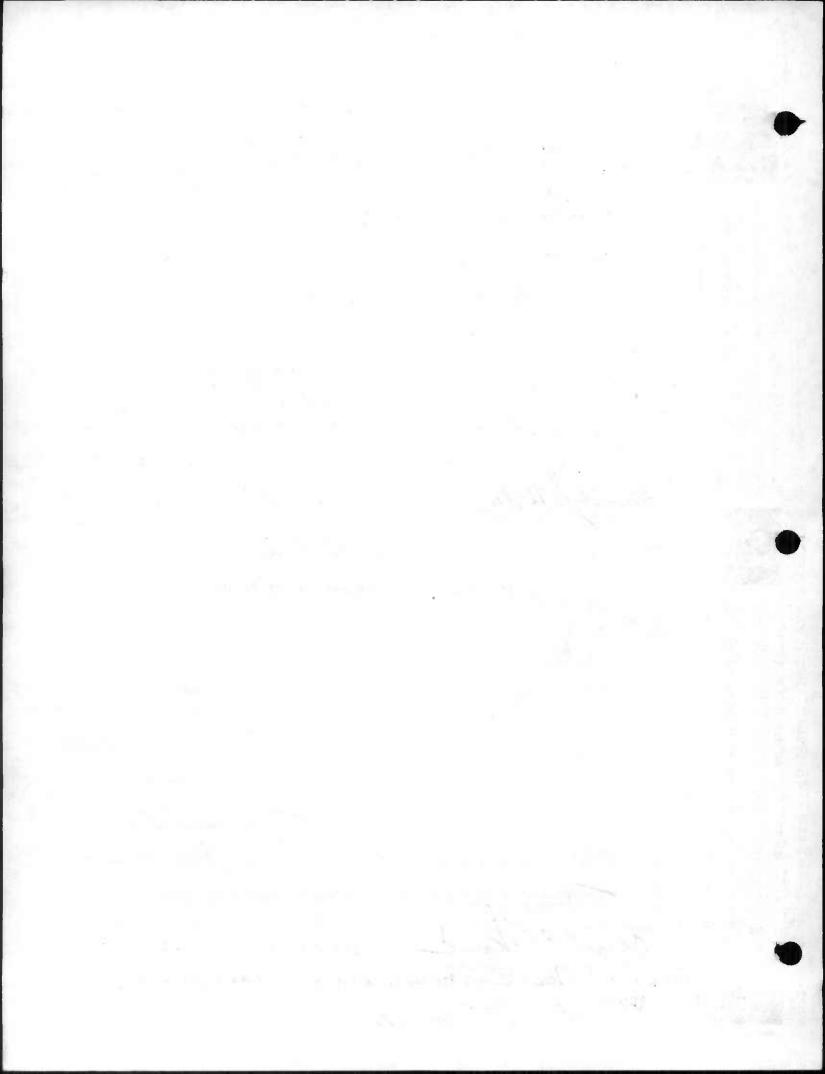
Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital



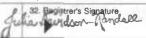
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Deeth 3. Time of Death 1. Decedant's Nama (First, Middla, Last) APRIL **Physician** 08:32 Otho Clinton Hawkins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) **Examiner** BALTIMORE ST AGNES HOSPITAL If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 10 M 2□ F 220-01-6450A 79 Yrs. **Director** Nov. 27, 1918 Md. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. n/a Baltimore XXYes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21217 701 N. Arlington Avenue Apt. 315 USA death \ Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Dyes 2 No 1944 If Yes, Give Yaer or Dates: 1946 filed within 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Hygiena. Steelworker Bethlehem Steel 12th Grade 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Jermiah Hawkins Nellie Woods Is marked 19e. Informent's Name/Reletionship (Type, Print) sister 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Haaith an 2930 Windsor Avenue Baltimore, Md. 21216 Harriett Madison 20b. Plece of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition permit. Pages Department of Important: If It eny Injury or o Burial 2 Cremetion 3 Removel from State Garrison Forest Veterans April 29 Owings Mills, Md. 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. derver 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on aech line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceusa (Final disaese or condition resulting in deeth) CONGESTIVE HEART 2 YEARS Examiner Due to (or es e consequence of): 2YEARS FIBRILATION Physician/Medical Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avants Due to (or es e consequence of) Dua to (or es a consequence of) 2 resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 2 3 Probably 4 Unknown yd bengis 1 ☐ Yes 2 ☐ No D. Part P CHRONIC OBSTRUCTIVE PULMONARY of Vital Records, by 24b. Wera autopsy findings available prior to 24a. Wes en eutopsy performed? CEREBRA VASCULAR ACCIDENT completion of cause of deeth? 1 ☐ Yas 2 ☑ No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) i or Attending Physic after death. Director: After this o 5 1 Yes 2 No fumeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as steted. edicai (Check only one) 2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11706 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

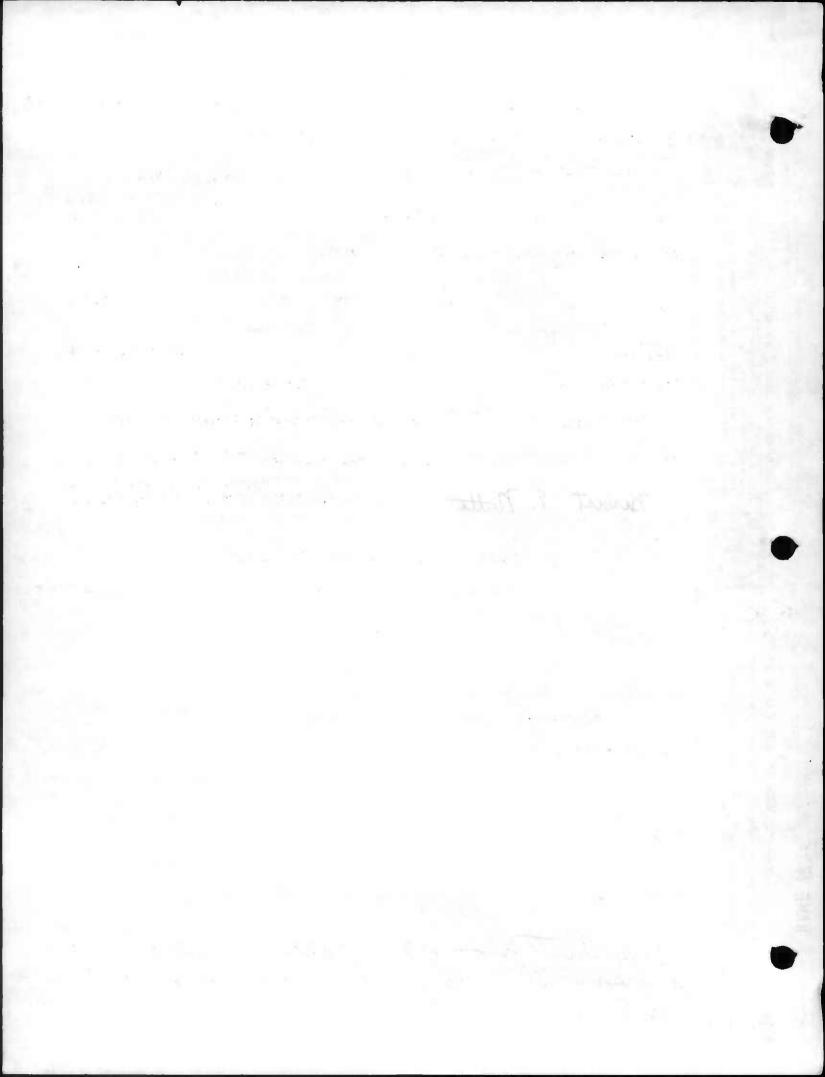
IVAN AKSENTIDEVICH, STAGNES HOSPITAL 900 CATON AVENUE

State Registrar

31. Dete filed (Month, Day, Year) APR 2.7 1998



142×15



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death

		Certificate of Death	Reg. No.	0 13000
	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Dey	3. Time of Death
Physician /Medical	RUTH HINTON	AT	25 25	
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Locat		County of Death
	SINAI HOSPITAL	BALTIMO	DRE	NA
Funeral Director	5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 M 7. Age (In yrs. I) Usual Residence of Decedent	lest birthdey If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
ž		y, Town or Location	1000	10d. Inside City Limit
ms 23a or 23a-f show result be notified.	mb NA B	altimore		1 Dres 2 □ N
288 notifie	10e. Street and Number	10f. Zip Code	10g. Citiz	en of What Country?
r items 23a or 28a-f si other mant be notified Funeral Director	3008 Woodland Ave	21215	(5)	2.2
ma 2	11 Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric		4. Race - American Indien,
if, or he by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ric		Black, White, etc. Specify: Black
Mentel Hygiene. Irked other than "natural; site event, the Medical Ext	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kin	d of Business/Industry
	(Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		
To.	12th NA	Supervisor	Soci	al Security Adm
To Health and Mentel Prigience in the Health and Mentel Prigience or other traumatic event, the Mentel Price III To Be Comp	17. Father's Name (First, Middle, Last)	18. Mother's Neme (F	irst, Middle, Meiden S	Sumeme)
To the	Koland Johnson	Julia	Wate	R5
and sand	19a, Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural R	0	
Health tem 27 other tr	Carolyn Shanklin-Daug			alto md 2121
of He	20a. Method of Discosition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, cremetory or other place)		ation - City or Town, State
int: H		ina Men. Park 4.	28.98 Rai	sdall stown M
Department of Important: If it is any injury or once.	21. Sandure of Funeral Service Licensee	00 Name and Address of Facility a	peral Ho	me West FAC
Depar Impor	Mulan B. Hannes	1.000	0 ()	
	23a. Fartt. Enter the disease, or complications that caused the death shade, or heart future. List only one cause on each line.		(, month)	Approximete
hysician	and the maintailure. List only one cause on each line.			Interval Between Onset and Death
/Medical	Immediate Cause (Final	ONARLY EMBOLISH	۸ -	
xaminer		r as a consequence of):		
Je L		ATIVE - CORONARY ARCT	FRY BY	ZASS
Examiner	0.	r es a consequenca of):	4	
EX EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
edicai	that initiated events	r as e consequence of):		
	resulting in deeth) Lest			
for use	d			
hed for a	Part II Other elanificant conditions contributing to death but not resu			
E W 01		ulting in the underlying cause given in Part I.	23b. Did tobacco u	use contribute to the cause of deat
hy hy		ulting in the underlying cause given in Part I.		1.
e detach y Phy	MY OCARDIAL INFARCTION		23b. Did tobacco u 1 ☐ Yes 2 ☐	1.
n signed by a uid be detach	MY OCARDIAL INFARCTION		1 Yes 2	No 3 Probably 4 Unkno
been signed by a should be detach			1 Yes 2	sy 24b. Were autopsy findings aveilable prior to completion of causa
s has been signed by the gas 2 should be detach ompleted by Physical physical by Physical	MYOCARDIAL INFARCTION PERIPHERAL VASCULAR	DiSEASE	1 Yes 20	Sy 24b. Were autopsy findings aveilable prior to completion of cause of death?
ate has been signed by the page 2 should be detact Completed by Phy	MY OCARDIAL INFARCTION PERIPHERAL VASCULAR CHRONIC OBSTRUCTIVE PU	DISEASE PLMONARY DISEASE	1 Yes 2	sy 24b. Were autopsy findings aveilable prior to completion of causar
certificate has been signed by the metics, page 2 should be detached by the metics, page 2 should be detached by Physical by Physical by Physical by Physical by Physical by Physical by Physical by Physical by Physical by	MY OCARDIAL INFARCTION PERIPHERAL VASCULAR CHRONIC OBSTRUCTIVE PU 25. Was case referred to medical examiner? Heapital:	DISEASE PLMONARY DISEASE 26. Place of Death (C	1 Yes 20 24a. Was an autops performed? 1 Yes 2	Sy 24b. Were autopsy findings aveilable prior to completion of causs of death? 1 Yes 254-No
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hin 24 hours after death. The Funeral Director: After this certifingleshy filled in by the funeral director. Aedical Certification: To Be	My ocarDial infarction PERIPHERAL VASCULAR CHRONIC OBSTRUCTIVE PU 25. Was case referred to medical examiner? 1 yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At he building, etc. (Specify Check only one) 29a. Certifier (Check only one) 29b. Signature and title of cartifier	DISEASE 26. Place of Death (Company) 28b. Time of Injury Mork? Mork? Mork at Mork and Place, end tion and/or investigetion, in my opinion, deeth occurred at the time, date and place, end tion and/or investigetion, in my opinion, deeth occurred age.	1 Yes 2 24a. Was an autops performed? 1 Yes 2 Check only one) 5 Residence 6 d. Describe how Injury Location (Street end City or Town, Stete) I due to the ceuse(s) et the time, date and 29d. Date	24b. Were autopsy findings aveilable prior to completion of cause of death? 1
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DHMH 16 Rev 6/95

